State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar 3550 I Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Elliott Sal **Physician** MALCOL 10 060 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner hester River Christertown HOSP. Center Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1□M 2**X**F Hours Director -Lovac 56 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State and Mental Hygiene. Is marked other then "natural", or items 23a or 28a-f show raumatic event, the Maulical Examilian is and be notified at DRIDA 1 ☐ Yes 2 ☐ No Completed by Funeral Director an 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21678 Peges 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 Deno If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11, Marital Status Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: Buck 3 ☐ Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be NICK 2 19a. Informant's Name/Relationship (Type, Print) Department of Health a Importent: If Item 27 is any injury or other tra 2005. analla 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Uarow Charal len 21. Signal re V Fymeral Service Licensee 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEVERE **Physician** EMPHYSEMA 5 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Dus to (or as a consequence of) n any, leading to inimediate cause. Enter Underlying Cause (Disease or injury attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 \$No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 € No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No this certificate 25. Was case referred to medical examiner? 26. Place of Death [Check only one] Medical Certification: To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2√ No 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funerel Director: After th completely filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending М 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number Į. 29b. Signature and title of certifier D0041587 8 mis 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chestertown. MD M.D 122 Speer Rd. Noble 32. Register's Signature 31. Date filed (Month, Day, Year) State 2006

DHMH 17 Rev 1/2001

Registrar

			For State	5	State o	f Marylai		artment			and M	ental Hyg		2006	35	502
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	Director		365-44-3661	1 1 1	4 2 <b>∏</b> F	6.5	Yrs.	IVIOTITIS	Days	710013		Feb 28			higan	
	D		Usual Residence of Decedent  10a. State 10b. Coun	hv		10c C	ity, Town or Lo	ocation							10d. Inside C	ity Limite
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	Physician		shock, or heart failure. L Immediate Cause (Final	st only one	cause on e	A7	6								Onset and	
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н	Director		578-09-0841 1 <sup>23</sup>	M 2□F	88	Yrs.	Months Days	Hours	Min.	<i>(Month, Day</i> March 1	, <i>Year)</i> 8. 19	918 W	Country) ashi	naton.	. DC
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "netural; or items 23a or 28e-f show any injury or other treumatic event, it e Mydical Examples usual be notified at ance.	Funeral Director		2. Was Decede	ent Ever in U.S.	. 13.	Was Decedent of Hi	spanic Orig	gin? (Spec	city Yes or No-	14.	Race - A	merican I	Indian,	
	riter liner	Fur	1 ☐ Never Married 2 🔀 Married	Armed Force		- 1	f Yes, specify Cuba	n, Mexican,	, Puerto A	tican, etc.)		Black, W	hite, etc.		
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			23a. Part1. Enter the disease, or complice shock, of heart failure. List only on	ations that cau	sed the death.								Ap	proximate	-
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Вох	death certifi e attending id for use as	an/	23b. Was decedent pregnant in the past 12 months?		me of pregnand h 2 □ Fetal d		Ectopic pregnancy				230	f. Date of Month	delivery Day	v Year	,
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Division	r Att	Certification;	3 Suicide 6 Could not be determined	28e. Place of building	Injury - At hom , etc. (Specify)	ne, farm, str	eet, factory, office		2	8f. Location (Si City or Town		lumber or	Rural Ro	oute Number,	
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	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	29a. Certifier Certifying Phys	ician: To the beer: On the basi	is of examination	ledge, death on and/or in	n occurred at the tim vestigation, in my or	ne, date and pinion, deati	d place, ar	nd due to the c d at the time, d	ause(s) an late and pl	d manner	as stated	d. e cause(s)	
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			For State	State	of Marylan	•			Mental Hygie	2000	05501
			Registrar			Cei	tificate of L	Jeath		NOC UUD	35504
	Physicia		1. Decedent's Name (First, Middle James Jeffrey	. ,					2. Date of Death Month	Day Year 22, 2006	3. Time of Death 5:40
	/Medic Examin		4a. Facility Name (If not institution	n, give street and n	umber)		4b. City, Town, or	Location of Death		4c. County of Dea	
			Montgomery Ge	neral Hos	pital		Olne	У		Montg	omery
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		thplace (State or Foreign ountry)
	Director		206-32-0848	1√2 M 2 □ F	62	Yrs.	Months Days	TIOUIS IVIII.	Dec. 31,		nnsylvania
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	er de Item	E I	11. Marital Status	Armed F	cedent Ever in U. forces?	.S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Si n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
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	artme ortan injur	}	21. Signature of Funeral Service	· · · · · · · · · · · · · · · · · · ·	Met		an Cremator		2006 s Funeral		a, Virginia
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			23a. Part1. Enter the disease, or		caused the deat						Approximate
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Q Q	g phys as the	ed									
XOD	n certific anding pl use as t	2	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna		Ectopic pregnancy			23d. Date of de	livery
מ	death e atten	ic a	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time of d		Other (specify)			Month	Day Year
<i>.</i>	wrequires thet the death certific been signed by the attending p should be detached for use as:	Physiclan/Me	9 Unknown	9L Unk	nown						
ກົ	gned on de	by F	Part II. Other significant conditi	ons contributing to	death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
5	en si								1 ☐ Yes	2 □ No 3 □ P	robably 4 🖯 Unknown
ecor	aw re as be 2 sh	Completed							24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
Ē	The law ste hes b page 2 st	Eo							performe	d?   death?	s 2 No
N Ear	ian: rtifica ctor.	Bec	25. Was case referred to medica examiner?	ıl				26. Place of Dea	th (Check only one)		
_	nysic nis ce dire	10	1 ☐ Yes 2 ☐ Mo	Hospital:	Impatient 2	ER/Outpatier	nt 3 DOA Othe	er: 4 Nursing H	ome 5 Residen	ce 6 □Other (Spe	ecify)
0	ng Pl		27. Manner of Death 1 ☑Natural 5 ☐ Pendi	28a. Date (Mc	e of Injury onth, Day Year)	28b. Time o Injury		at	28d. Describe how		
<u> </u>	endii path. br: A	atk	2 Accident invest	igation				Yes 2 □ No			
DIVISION	r Att	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286. Plac	ce of Injury - At he ding, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	lural Route Number,
2	To the Hospitel or Attending Physicien: The law within 24 bours after death. To the Funerel Director, After this certificate hes completely filled in by the funeral director, page 2										
	Hosp 24 hos Fune tely fi	edical	(Check only 2 Medical	Examiner: On the	basis of examina	wledge, deat ition and/or in	h occurred at the tim vestigation, in my or	ne, date and place pinion, death occu	, and due to the cau irred at the time, date	se(s) and manner a e and place, and du	s stated. e to the cause(s)
	the the	Med	one) 29b. Signature and title of certifie		nner stated.		29c. License	number	200	I. Date signed (Mon	th Day Year
	FEFE	_	h h		R MM				-	D DIL	7.00(a
,	10		recess				DC	1036	(6)	10/27/	
			30. Name and address of person	who completed car	use of death (Item	n 23a) (Type.	Print)	6lnes	10010	0027	
	Sta	ta.	31. Date filed (Month, Day, Year	) 18	egistrar's Signa	iture 4	Dill IN	VINCE	1111) 6	0836	
	Registr			6 2006	Marca d	K de	ale				

physician and s the burial-transit certificate

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

e, Maryland 21215-0036

Baltimore,

show

"natural", or items 23a or 28a-f shor dical Examiner must be notified at

other traumatic event, the Medical

other t

Department of Health and Mental Important: If Item 27 Is marked of any Injury or other traumatic even

attending p for use as cate has page 2 s Hospital or Attending Physician: funeral director P E P

	Neith Control
CR	(2)
8	Si Regis

Certification: hin 24 hours after death.

the Funeral Director: #

mpletely filled in by the fi 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 29a, Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) ME D55550 23 2006 2080120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7572 MITSURV 4 RESTA CENTOR DRIVE 31. Date filed (Month, Day, Year) . Registrar's Signature ate OCT 25 2006 rar

					ndelible ink. Ensure A partment of Health and N	•	•				
			1- State Amended 5,10/24/06,	LDB, DOR Ce	ertificate of Death		2006	35506			
	hysicia		1. Decedent's Name (First, Middle, Last)  Howard James Fitzhugh	i		2. Date of Death Month October	Day Year 18, 2006	3. Time of Death 18:35 M			
	/Medic xamin	_	4a. Facility Name (If not institution, give street and no		4b. City, Town, or Location of Death	10020001	4c. County of Dea	th			
Fu	neral		Chesapeake Woods Nursi 550 ial Security Number 210-12-2477  6. Sex	7. Age (In yrs. last birthda)	Cambridge  y) If Under 1 Year   If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day,	rear)   Co	hplace (State or Foreign			
	ector		Usual Residence of Decedent	95 Yrs.		Dec. 16,	1910 Mar	yländ			
Aanylan	a pa	ō	10a. State 10b. County Maryland Dorchester	10c. City, Town or	Location dville			10d. Inside City Limits 1 ☐ Yes 2 ☐ No			
it the	or 28a-	Funeral Director	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Co				
dath 2	ms 238	erai	2723 Toddville Road  11. Marital Status 12. Was De	cedent Ever in U.S. 13	3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	US 14. Race - Ame	erican Indian,			
LICE STORY OF THE MANY AND THE	"natural, or items 23a or 28a-f show	þ	Amed F	2 <b>141</b> 0 ive	If Yes, specify Cuban, Mexican, Puento 1 ☐ Yes 2 ☐ No Specify:	Rican, etc.)	Black, Whit	e, etc. White			
in 72 h	n natu	Completed	15. Decedent's Education (Specify only highest grade completed	) (Giv	cedent's Usual Occupation we kind of work done during most of work . DO NOT use retired)	ting	6b. Kind of Business Transn	ortation			
filed with Hygiene.	ner tha		10	(1-4or 5+) Bus (	Contractor & Water		and Shell	fish			
2 should be finand Mental H	is marked other than eumatic event, ILS M	To Be	17. Father's Name (First, Middle, Last)  Levin J. Fitzhugh			e (First, Middle, M. ttie Wils					
VICE Should hand Men	if item 27 is marked other than or other treumatic event, ILS M		19a. Informant's Name/Relationship (Type, Print) Regina Wroten/Daughter		illing Address (Street and Number or Rul			•			
s tand	other I		20a. Method of Disposition	20b. Place of Dis	19 Landrum Dr., Eas		CREE, MD Oc. Location - City or				
Last New Market Cemetery 10/23/2006 East New Market Cemetery 10/23/2006 East New Mar											
permi Depa	any ir		Webles Adult Of	nevell	Curran-Bromwell Fi 308 High St., Cam	neral Ho	me 1714.				
	Α.		23a Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final	caused the death. Do not e each line.	enter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death			
/Me	ician dical		disease or condition resulting in death)	o (or as a consequence of):	,, ,			10 years			
	niner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Undertrying Cause (Diseese or injury	triel fibrio (or as a consequence of):	illation			104E015			
be executed	ysician and le burial-transit	Examiner	that initiated events c.	(or as a consequence of):			10				
10 Co (	ysician ie burial	cai	d	(or as a consequence or).							
certificat	ding ph se as th	/Medi	IF FEMALE: 23c, If yes, o	utcome of pregnancy			23d. Date of de	livon			
the death cer	ed by the attending phys detached for use as the	hysician/Medi	in the past 12 months?	birth 2 Fetal death 3	3 □Ectopic pregnancy 5 □ Other (specify)		Month	Day Year			
The law requires that the death certificate	s been signed to should be deta	by P	Part II. Other significant conditions contributing to	death but not resulting in the				o the cause of death?  robably 4 □Unknown			
The law r	ite has	Completed				24a. Was an autopsy perform 1  Yes 2	prior to	utopsy findings available completion of cause of 2 No			
VII.dil /sicien: 1	s certific director,	To Be	25. Was case referred to medical examiner?  1 \( \subseteq Yes \) 2 \( \subseteq No \)  Hospital: 1	Inpatient 2 ER/Outpat	Ou Title	th (Check only one	nce 6 Other (Spe	ocify)			
To the Hospitel or Attending Physicien: within 24 hours after death.	r: After this le funeral c		27. Manner of Death 28a. Dat	e of Injury onth, Day Year)  28b. Time Injury	of 28c. Injury at	28d. Describe how		city			
DIVISION of or Attending after death.	l Directo d in by th	ertification:	3 Surcide 6 Could not be determined buil	ce of Injury - At home, farm, ding, etc. (Specify)	street, factory, office	28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,			
ne Mospite n 24 hours	To the Funerel Director: completely filled in by the	edicai C	(Check only 2 Medical Examiner: On the	ne best of my knowledge, de basis of examination and/or nner stated.	path occurred at the time, date and place, investigation, in my opinion, death occur	and due to the car red at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)			
To the within	Comp	M	29b. Signature and title of certifier	)	29c. License number		d. Date signed (Moni				
			30. Name and address of person who completed ca	use of death (Item 23a) (Typ		0 1	001171100				
	21881		Dr. Patricia Johnson, 31. Date filed (Month, Day, Year) 32.	100 Bramble :	St., Cambridge, MD	21613					
	Sta Registi		OCT 2 0 2006	May &	port						

		For AMEND#19a per FH State Registrar 11/1/06 CMH AA	-0 t/	/land / De г. С	ertifica				Re	g. No2 (	006	35507
Physicia	an	Decedent's Name (First, Middle, Last)							. Date of Death Month	Day	Year	3. Time of Death
/Medic		Reginald	Т.		Gibs				October	21	2006	2:00 p M
Examin	er	4a. Facility Name (If not institution, give					r Location of I	Death			nty of Death	1 1
		517 Harbor Drive 5. Social Security Number 6. Sep		yrs. last birthd		napo. ler 1 Year		Hrs. 8	. Date of Birth		nne Ar	
Funeral Director			M 2□F 7	•	Month	s Days	Hours	Min.	Date of Birth (Month, Day, Oct 11	Year) 1928		olace (State or Foreig otry) vland
		Usual Residence of Decedent			1					1,20	TIALY	Tand
Tal.	_	10a. State 10b. County	10	c. City, Town or	Location						1	Od. Inside City Limits
Ba-f	cto	MD Anne Aru	nde1	Ann	apolis	3						1 ☐ Yes 2 ☐ No
Copputation to restitute and waster typered.  Department of restitute 21 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examinar must be notified at 2006.	by Funeral Director	10e. Street and Number			10f. 2	Zip Code			10	_	of What Cour	ntry?
230	rai	517 Harbor Drive				2140					USA	
Detr	nue	77	12. Was Decedent Eve Armed Forces?	r in U.S. 1	3. Was Dec	edent of H ecify Cuba	lîspanic Orîgîr an, Mexican, I	n? (Specif Puerto Ric	fy Yes or No- can, etc.)		Race - Americ Black, White,	
Kam	Jy F	1 ☐ Never Married 2 ⚠ Married 3 ☐ Widowed 4 ☐ Divorced	1. A Yes 2 □ No If Yes, Give Year or Dates: K	orea	1 🗆 Yes	2. No	Specify:			Spe	city: Wh	ite
E E		15. Decedent's Edu			cedent's Us	sual Occup	ation		1	6b. Kind o	f Business/In	dustry
Andle	piet	(Specify only highest grade	completed)	(G	ive kind of t e. DO NOT	vork done (	durina most a	of working	'		, , , , , , , , , , , , , , , , , , , ,	
2	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 2	Of	ficer					State	of Ma	ryland
/ent	Be C	17. Father's Name (First, Middle, Last)		, , , , ,			18. Mother's	s Name (/	First, Middle, M	laiden Sun	name)	
tic e	To B	Robert Gibson					He	len N	Moore			
EL I		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. M	ailing Addre	ss (Street	and Number	or Rural P	Route Number,	City or To	wn, State, Zip	Code)
12		<del>Jean</del> <del>Joan</del> Gibson (Wife	)	517	Harbo	r Dr	ive, A	nnapo	olis, M	D 214	03	
0		20a. Method of Disposition  1 Burial 2 K remation 3 F		20b. Place of Di cemetery, o	sposition (A	ame of rother plac	ce)	Dat	te 2	Oc. Location	on - City or To	own, State
		4 □ Donation 5 □ Other (Specify)	emoval from State	Metro			1	0-24-	-2006	Balti	more,	MTD
, S		21. Signature of Funeral Service Lights	S						ome, P.			-
		172 J.	0,		12 1	kidge.	Ly Ave	nue,	Annapo	lis,	MD 214	01
		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the	death. Do not	enter the m	ode of dyin	ng, such as ca	ardiac or r	respiratory arre	st,		Approximate Interval Between
ian		tmmediate Cause (Finaf disease or condition	ARCHE	mus	1							Onset and Death
al		resulting in death)	Due to (or as a c				-					
er		Samentially list conditions	cocone	ong	1120	nd.	Del					TRE
-	Examiner	S pential y list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence of):								
	Kam	that initiated events resulting in death) Last	Due to (or as a c	oncoguance of):								
	cai E		D00 10 (01 <b>2</b> 3 a 0	onsequence or).								
	Physician/Med	IF FEMALE:	3c. ff yes, outcome of p	pregnancy						224	Date of delive	
!	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ 4 Pregnant at tim		3 ☐ Ectopic 5 ☐ Other (		′			250.	Month	Day Year
	ysi	9 Unknown	9□ Unknown		773	-,,,_						
ď	by Pi	Part II. Other significant conditions con	tributing to death but n	ot resulting in th	e underlying	cause giv	en in Part I.		23e. Did tob	acco use c	ontribute to the	he cause of death?
									1 ☐ Ye	s 2 🗆 No	3 Prob	ably 4 Unknow
- 2	ompieted								24a. Was an	24	b. Were auto	psy findings available
	E							_	autopsy	ed?	prior to co death?	mpletion of cause of
	C	25. Was case referred to medical					26 Place o	of Death #	1□Yes 2 Check only one	-	1 🗆 Yes	2 U No
	0 8	examiner?	lospital: t  Inpatient	2 ☐ ER/Outpa	tient 3□ I	Oth Oth			e 5 ☐ Reside		Other (Specif	5/1
idileral director, p	핕	27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. Tim	e of	28c. Injur	y at		d. Describe ho			<del>,</del>
	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day 1	e <i>ar)</i> In <del>i</del> u	M M	Wor	k? Yes 2∐No	0				
	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Pface of Injury building, etc. (	- At home, farm	street, fact	ory, office	-	28	f. Location (Str City or Town	eet and Nu	imber or Rura	al Route Number,
	Cer		Duilding, etc. (	Specify,					ony or rown	, Diaio)		
Į.		29a. Certifier 1 Cartifying Physical Exami	vician: To the best of m	ny knowledge, d	aath beeum	d at the tw	ne, date and	place av	d due to the ca	uso(s) and	manner as e	tated,
completely filled in by the	Medicai	one)	and manner stated	J.	rinvestigati	on, in my o	pinion, death	000001190	rat the thire, ca	te and plac	ce, and due to	the cause(s)
000	2	29b. Signature and title of certifier	11	1	2	9c. Licens			29		ned (Month,	-
		fin Mille	a- 1111)			1/	30718	8		10.2	if-200	26
		30. Name and address of person who co	A	h (Item 23a) (Ty	pe, Print)		. ,	550	21401			
	1	1 Jackson, 20071	went Ake	4 10	un	co los	X	a.	21801			
		31. Date filed (Month, Day, Year)	32. Registrar's	9	9-			-				

		1 - For State Registrar	State of	Marylar	nd / Depa <i>Cel</i>	artmer <i>tificat</i>	nt of H	ealth a Death	nd Me	ental Hyg	iene og. No.20	06	355	08
Physici		Decedent's Name (First, Middle, Last)     TRIEU CHI GIANG								2. Date of Dear Month	Day 19, 2006	Year	3. Time of E 9:32	Death AM
/Medic Examin		4a. Facifity Name (If not institution, give s 13720 IVYWOOD LANE	street and num	ber)		4b. City,		Location of		OCTOBER	4c. County	of Death		
Funeral Director		213-94-4646	IM 2□F	7. Age (In yrs. 94	last birthday) Yrs.	If Unde Months	1 Year Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day APRIL 01	, Year)	9. Birthj Cou	place (State or ntry) CHINA	Foreign
Maryland	ctor	Usual Residence of Decedent           10a. State         10b. County           MARYLAND         MONTGOMER	Y	10c. Ci	ty, Town or Lo	cation	SPRING						10d. Inside City	•
with th	I Director	10e. Street and Number  13720 IVYWOOD LANE				10f. Zip	Code	20904		1	0g. Citizen of \	What Cou	ntry?	
within 72 hours after deeth with the Maryland jiene. Then "naturel", or items 23a or 28e-f show the Medical Examirar must be recilled at	by Funeral		12. Was Dece Armed For 1 ☐ Yes If Yes, Give Year or Da	ces? 2⊠No e		Was Dece f Yes, spe 1  Yes				ify Yes or No- ican, etc.)	14. Rac	e - Ameri ck, White,	can Indian, efc.	
within 72 ho jiene. r then "netur the Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12		4or 5+)	16a. Deced (Give life.	dent's Usu kind of wo DO NOT u	rk done d	uring most	of working	g	16b. Kind of Bi		odustry	ANY
s 1 and 2 should be filed within 72 hours all f Heelin and Mental Hygiens. I same filed price than "natural", or other traumatic event, the Medical Exami	To Be C	17. Father's Name (First, Middle, Last) UNKNOWN								(First, Middle,	Maiden Suman			
		19a. Informant's Name/Relationship (Ty) CHELSEY WONG - GRANDD									City or Town, MARYLA			
00		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		State	Place of Disponentery, cremetery, cremetery	natory or o	other place		Da 0/21/2		20c. Location -			
permit. Pag Depertment important: i any injury o		21. Signature of Funeral Service Livense		Ou .	22 F	. Name ar	nd Address	s of Facility I FUNE	RAL HO	OME, INC.	ER SPRIN			1904
death cartificate be executed  (Madical Example 1	dical Examiner	disease of condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (c	or as a consec	kience of):	METASI	A515						NOV. 200	
death certif e attending ed for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		nth 2 ☐ Feta ant at time of c	aldeath 3	]Ectopic p. ] Other (sp						te of deliv	,	ear
g 25 25	ρ	Part II. Other significant conditions cor OBSTRUCTIVE JAUNDIO		ath but not res	sulting in the u	nderlying o	ause give	n in Part I.			bacco use cont			
The law ate has b	Completed	CHRONIC ANEMIA HYPERLIPIDEMIA								24a. Was a autops perform	med?	prior to co death?	opsy findings a impletion of car	vailable iuse of
Physician: T ir this certificat sral director, pe	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death	ospital: 1 ☐ Ir 28a. Date o (Monti		ER/Outpatier		_	r: 4□Nur	sing Hom		ence 6 Oth		<b>(y</b> )	
or Attending ( efter death. Director: After d in by the funer	Certification:	1 🖾 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place		Injury ome, farm, str	М		? ′es 2 □ N		Bf. Location (Si City or Town	treet and Numb	er or Run	al Route Numb	oer,
Hospita 4 hours Funerel	ledical Cer	29a. Certifier 1 \( \bigcirc Certifying Physics (Check only one) \)	sician: To the	best of my kno	owledge, deati	occurred	at the tim	e, date and	place, ar	nd due to the c	ause(s) and ma ate and place,	anner as s	stated. o the cause(s)	
(	Med	29b. Signature and title of certifier	and mann	er stated.			c. License				9d. Date signe	d (Month,	Day, Year)	
12		30. Name and adjects of person who co	mpleted cause	of death (Ite	m 23a) (Type,	Print)	D26	5707			OCTOBER	20, 2	006	
Sta Registr		31. Date filed (Month, Day, Year)	UCK INCH. 32.	M DE IVE	SILVET.	SFRIN	C, MAI	YLAND	20501					

			1 - For State Registrar	State of Maryla		artmen rtificat			ind M		jienę eg. No.	006	355	509
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Bernice H. Gall	oway						2. Date of Dea Month October		2006	3. Time o	
	Examir		4a. Facility Name (If not institution, give si Calvert Manor Healt	hcare Center		Risi	ing S		0.77		Cec	unty of Death		
	Funeral Director		5. Social Security Number 183-09-6131 6. Sex	7. Age (In yrs	. last birthday) Yrs.	If Under Months		If Under 2 Hours	Min.	8. Date of Birth (Month, Day 07/29/1		9. Birth Cou PA	place (State intry)	or Foreign
	72 hours after death with the Maryland natural; or Items 23a or 28e-f show alcal Examiner must be mulfied at	al Director	PA Chester  10e. Street and Number 469 East State Roa	We	ity, Town or Lo	Ve 10f. Zip	Code 9390			1	0g. Citizer US	n of What Cou		ity Limits 2 No
-0036	72 hours after deal "natural", or Items :	ed by Funeral	11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ	2. Was Decedent Ever in I Armed Forces? 1 Tyes 27 No If Yes, Give Year or Dates:		1 ☐ Yes	2 <b>∏</b> No	Specify:	gin? (Spe , Puerto l	ocify Yes or No- Rican, etc.)	Sp	Race - Amer Black, White pecify: wh	ite	
21215-0036	within ene. than *	Completed	(Specify only highest grade Elementary/Secondary (0-12)  12		Homen	kind of wo DO NOT u	ork done di se retired)	uring most			own ]		ndustry	
Maryland	d 2 should be filed th and Mental Hygi 7 Is marked other traumatic event, I	To Be	17. Father's Name (First, Middle, Last)  Kelso Johnson  19a. Informant's Name/Relationship (Typ	e Print)	19h Maili	na Address		Ella	a Fai	(First, Middle, i Cra   Route Number			n Codol	
Baltimore, Ma	permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any injury or other trau		Errol L. Galloway/  20a. Method of Disposition  1 X Burial 2 Cremation 3 Re  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Letts	Son 20b.	2112 Place of Disponder London	Newai psition (Nar matory or o	rk Rd me of other place IC Cel	n. 1	0/28	Grove, I	PA 19: 20c. Local New I	390 ion - City or T ondon,	own, State	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the deal cause on each line.  Due to (or as a conse	th. Do not ent	ter the mod	de of dying		cardiac o				Approxima Interval Be Onset and	te tween
8760,	cate be executed by sician and the burial-transit	dical Examiner	55 and telly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last  d.	Due to (or as a conse										
.O. Box 6	death certifii e attending f id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \) 9 \( \text{Unknown} \)	c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	aldeath 3	Ectopic pr					23d	. Date of delive Month	•	Year
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	To the Hospital of within 24 hours at To the Funerel Completely filled it	ledical	29a. Certifier (Check only one) 2 Medical Examin	cian: To the best of my kn er: On the basis of examin and manner stated.	owledge, death ation and/or in	h occurred vestigation	at the time , in my op	e, date and inion, deat	i place, a h occurre	and due to the ca ed at the time, d	ause(s) and ate and pla	d manner as s ace, and due t	stated. o the cause(s	5)
)	To the within 2 To the complet	Σ	29b. Signature and title of certifier				C. License		54	2	9d. Date s	igned (Month,	Day, Year)	
	10		30. Name and address of person who com	npleted cause of death (Ite	m 23a) (Турө,	Drint\			Ris	ing Sui	M	0 20	711	
	Sta Registi		31. Date filed (Month, Day, Year)  OCT 2 5 200	32 Aegistrar's Sign	ature do	ONIA		71	•	7				

State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 1 = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ves **Physician** Gladmon 1745 atherine actuber 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove
5. Social Security Number hdvon tist Hospita Rockville Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex Funeral 7. Agé (In yrs. last birthday Birthplace (State or Foreign Country) Days 1 M 2 F Months Hours Min. Director 89 March 9. 1917 Washington, 219-48-6698 Usual Residence of Decedent deeth with the Maryland 10a. State 10c. City. Town or Location 10d. toside City Limits 10b. County r items 23e or 28a-f ehow instructs be notified at 1 ☐ Yes 2X No Montgomery Village Maryland Montgomery Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20886 USA 10352 Ridgeline Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritat Status Black, White, etc. should be filed within 72 hours after 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Spec White þ 3 XWidowed 4 ☐ Divorced "natural", ed The Madical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Complet (Specify only highest grade completed) then Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mental marked Lyda Bingley Charles Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Depertment of Health and Importent: If Item 27 Ie m 10352 Ridgeline Drive, Montgomery Village, MD 20886 Paul H. Lucas/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State October 26, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2006 Silver Spring, Maryland Gate of Heaven Cemetery 21. Signature of Funeral Service Licenses Francis Address of Early ins Funeral Home Inc. ans 500 University Blvd, W, Silver Spring, MD 20901 2 23a. Part1. Enter the disease, or complications that cauled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat Physician disease or condition resulting in death) Myocardia. minetes /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner physician and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 D No Day Month Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No been sl Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy perform certificete 1 Yes 2 No 1 ☐ Yes 2 No or Attending Physician: the Funeral Director; After this certific mpletely filled in by the funeral director, 25. Was case referred to medicat examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification; Injury at Work? 1 Natural 2 Accident 5 Pending death. 1 Yes 2 No investigation 3 Suicide 6 Could not be determined 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Dire 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Joe IE. Burn 8910 31. Date filed (Month, Day, Year) Registrar's Signature State OCT 2 4 2006 Registrar

		ľ	For State Registrar	State of Mar	-	artment of rtificate of			jiene leg. No.2	006	35511
			1. Decedent's Name (First, Middle, La	st)				2. Date of Dea	th		3. Time of Death
	Physici		Catherine R. Gri	eshaber				Octobe:	r 22	2006	6:55 P M
	/Medio Examir		4a. Facility Name (If not institution, giv	re street and number)		4b. City, Town,	or Location ol Death			nty of Death	<del></del>
			Berlin Nursing &	Rehab Cent	er	Berlin.	MD 21811		Wo	rcest	or
	Funeral		5. Social Security Number 6. 5	Sex 7. Age (	'In yrs. last birthday)	Il Under 1 Yea Months Days	r II Under 24 Hrs.	8. Date of Birtl (Month, Day	1	9. Birth	place (State or Foreign intry)
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	sho.	2			oc. City, Town or Lo	cation					10d. Inside City Limits  X⊠Yes 2 □ No
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	with t		10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cou	int <b>ry</b> ?
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<b>K</b>	p E	nu	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 🕱 No		Was Decedent of If Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes of No- o Rican, etc.)		Race - Ameri Black, White	
ne 136	rs af	by	3 ∰Widowed 4 □ Divorced	If Yes, Give		1⊡Yes 2⊠No	o Specify:		Spe	city: W	hite
Catherine <b>d 21215-0036</b>	be filed within 72 hours after death with the Marylar tal Hygiene. d other then "natural", or Items 23a or 28a-f show avent, the Mudical Exambar must be notified at	ed	15. Decedent's E		16a. Dece	dent's Usual Occi	upation		16b. Kind of	f Business/Ir	ndustry
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Der, C.		To B	Frank Petrozzo				Mary Ve	rilli			
er ary	should Ind Men		19a. Informant's Name/Relationship (	Type, Print)	19b. Mailir	ng Address (Stree	et and Number or Ru		r, City or Tox	wn, State, Zi	p Code)
	od 2 lith a 27 is		Joseph Grieshabe	r (son)	20	02 Winge	ed Foot Ct	. Resto	n Va	2010	1
eshaber nore, Mary	f Health item 27 other tr		20a. Method of Disposition		20b. Place of Dispo			Date		on - City or T	
m e	m O		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		_		1	1.106	Frankf	ord T	) T
Griesha <b>Baltimore</b> ,			21. Signature of Funeral Service Lice		Cape Hen1	Open Cre 2. Name and Add			Frankf		
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	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after deeth. Within 24 hours after deeth. To the Funeral Director: After this certificate has been signed by the estending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier (Cortifying P	hysician: To the best of	over the southern teams	h depuesat as es-	floria chika anvi chia	and this in the	TALLE SET TO A	Concerne se	etalise
	To the Hospita within 24 hours To the Funeral completely filled	Medical		miner: On the basis of e	xamination and/or in	vestigation, in my	opinion, death occu	irred at the time,	date and place	ce, and due	to the cause(s)
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ST	- 2		Name and address of person who	completed cause of dea	un (IIIm 23a) (Type,	Print)	10 han 1	46.	Fam	Ar I	66 A 1994
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-			1 - For State Registrar	State of Ma	aryland / De	partment o	of Health a	and Mental H	ygiene 2	006 3551
	Dhysi	-:	1. Decedent's Name (First, Middle,	Last)				2. Date of	Death	3. Time of Death
	Physi /Med		Carroll Henry G	eldmacher J	r.			Month 10	2 2	Yeer 2006 0525
	Exam	iner	4a. Facility Name (If not institution,			4b. City, Tov	vn, or Location of			nty of Death
			Atlantic Genera			Berlin			Word	cester
	Funera Directo			5. Sex 7. Age 1. 1. Age	(In yrs. last birthda		ear If Under 2 ays Hours	Min. 8. Date of the Min. (Month,	Birth Day, Year)	Birthplace (State or Foreig Country)
			218-09-4190 Usuet Residence of Decedent	A -	87 <sup>Yrs.</sup>				21 1919	MD
	yland		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Mar.	Ď	MD Worcest	er	Ocean C	1 + 37				1 ☐ Yes 2X No
	h the	Director	10e. Street and Number		occur o	10f. Zip Coo	de		100 Citizen	of What Country?
	th wit	a C	12346 Old Bri	dge Rd.		2184			USA	or what Country?
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel; or items 23s or 28s-f ehow eny Injury or other treumatic event, the Madical Examinar must be notified at opce.	by Funeral	11. Marital Status	12. Was Decedent E	ver in U.S. 13	Was Decedent	of Hispanic Orig	in? (Specify Yes or ! Puerto Rican, etc.)	Į.	ace - American Indian,
9	after or ft	臣	1 Never Married 2 Marrie		0			Puerto Rican, etc.)	В	lack, White, etc.
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Maryland 21215-0036	d 2 s th an treur		19a. Informant's Name/Relationship					or Rural Route Num		
نه	1 an Heal em 2		Carroll H. Gelds 20a. Method of Disposition	macher, III	220 20b Place et Dies	98 Beav	er Dr.,	Denton, M		
ē	ages nt of t: # It		1 ☐ Buriat 2 XCremation 3		20b. Place of Disp cemetery, cre	matory or other	place)	Date	20c. Location	1 - City or Town, State
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			230 Part Enter the disease of the	ulp	1 1	OS MILL:	iam St	Berlin	MD 2181	1
	Physician /Medical Examiner		234. Part1. Enter the atsease, or oc shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. Athero Due to (or as a	sclerotic				arrest,	Approximate Interval Between Onset and Death Years
8760,	death certificate be executed e attending physician and dor use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С.	consequence of):					
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Ö	To the Hospital or Attending within 24 hours after death.  To the Funeral Director; Attercompletaly filled in by the funer	al Certification:	29a. Certifier (Certifying P	bysicism: To the best of a	Specify)			City or 18	wn, State)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Mental Hygien [ ] [ 5 tate of Maryland / Department of Health 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Evelyn M. 6 nffith 04:15 AM November 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Medical center Baltimore City If Under 1 Year If Under 24 Hrs. Min. 8. Date of Birth (Month, Day, Year) 05/19/1922 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F Yrs. Director 578-86-7984 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits rthan "natural", or itame 23a or 28a-f ahow Ita Medical Examinar must be notified at 1 Yes 2 No Maryland Prince George's Completed by Funeral Director Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5108 Wilkins Drive 20748 United States Pages 1 and 2 should be filled within 72 hours after death nent of Health and Mental Hygiene.
ant: If Itam 27 ie marked other than "natural", or Itame 23 arts yor other trannatic aven. If a Weden Exercite marray or other trannatic aven. If a Weden Exercite marray. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 IXNo Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard D. Randall Eva Bell Abel 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie L. Bell/Daughter 830 South River Landing Road, Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If any injury or once. Lakemont Memorial Gardens 11/04/2006 Davidsonville, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signatur 22. Name and Address of Facility George P. Kalas Funeral Home Melle 2973 Solomons Island Rd., Edgewater, Maryland 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** urosepsis /Medical Due to (or as a consequence of): Examiner tract Infection Urinary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Examiner or Attanding Physicien: The law requires that the death certificate be executed the burial-transit resulting in death) Last Division of Vital Records, P.O. Box 68760/ Due to (or as a consequence of): To Be Completed by Physiclan/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death signed by the er d be detached fo 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown insufficiency 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy oerforn 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Medical Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 1 Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a Certifier Cartifying Physician: To the best of my knowledge, death conursed at the time, date and place, and due to the cause(s) and manner as stated; 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 1.2006 ~ M.D. AU417643511 166621 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Ba (HMORE, MD SIK HUR M.D. 301 St. Paul Place 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 0 9 2006

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Ubaldo Herrera-Diaz 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death . Decedent's Name (First, Middle,Last) Physician/ Month Day October 29, 2006 0925 hrs Medical Examiner <u> Whaldo Herrera-Diaz</u> c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Montgomery 19117 Wheatfield Drive Germantown 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Social Security Number **Funeral** oreign Months Days Hours Director Country) Mexico 1990 16, Mav 1 X M 2 16 None Usual Residence of Decedent 10d. Inside City Limits 10b. Count 10c. City. Town or Location 10a, State 1 Yes 2 X No or 28a-f shov Maryland Montgomery Germantown or items 23a or 28a-f shormust be notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 20876 Mexico 19117 Wheatfield Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 X No Yes Specify: White Widowed Divorced If Yes, Give Year 1 X Yes 2 No specify: Mexican "natural", Š 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hou
Department of Heelth and Mental Hygiene
Important: If item 27 is marked other than "nat
injury or other transmatic event, the Medical Exa Elementary/Secondary (0-12) College (1-4 or 5+) Construction/ Renovations Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Juanita Diaz Jimenez Be Jesus Herrera Romero 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 19117 Wheatfield Dr., Germantown, MD Martin Herrera Diaz/Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State 10/7/2006 Morelo, Mexico Noxtepec Zaragoza 4 Donation 5 Other Specify: 22. Name and Address of Facility
Thibadeau Mortuary Service, P.A.
933 Gist Ave., LL Silver Spring, 21. Signature of Funeral Service Ligense M00956 20910 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death a. Acute Alcohol Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last g physician and the burial - transi sician/Medical UNPENDED **AMENDED** certificate be Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the attending por use as the 3 Ectopic pregnancy Year Month Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? 靣 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o Ď 1 Yes 2 ✓ No 3 Probably 4 Unknown σ. Completed Records, page 2 should 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? 1 ✓ Yes 2 No 1 🗸 Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 26.Place of Death (Check only one) 25. Was case referred to medical of Vital director, Be examiner? Hospital: Other ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene Inpatient 1 Yes မ Lyloan +-+ 28a. Date of Injury FOUND: 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Unknown FOUND: Division 1 Natural 1 Yes 2 ✔ No by the 0841 hrs Oct 29, 2006 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be filled in Suicide or Town, State) 19117 Wheatfield Drive, Germantown, MD determined (Specify) Single Family 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical To he l within 2 To he l con plete 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1 MID October 30, 2006 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner 31. Date filed (Month,

State

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Walker (41650

egistrar's Signature

2006

			For State Registrar	State o	f Marylar		artment of I		and Mer		iene .g. No2 0 0 8	35515
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	me.	Funeral	11. Marital Status	12. Was Deci	edent Ever in U	.S. 13.	Was Decedent of h	Hispanic Orig	gin? (Specify	Yes or No-		nerican Indian,
9	be filed within 72 hours after death with the Maryland tal Hyglene d other then "natural", or iteme 23s or 28s-f ehow event, the Medical Examinar must be untified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Fo 1 1 ☐ Yes If Yes, Gin Year or D	21 No /8		1 ☐ Yes 2 ☐XNo	Specify:	,		Specify: W	
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<u>6</u>	s 1 and i i Health item 27 other tra		20a. Method of Disposition	Daugitte	20b. F	face of Dispo	sition (Name of		Date	Gait	hersburg, 20c. Location - City	Maryland or Town, State
Ē	Page: lent o nt: If iry or		1 ☑ Bunal 2 ☐ Cremation 3 4 ☐ Qonation 5 ☐ Other (Spe		State		natory or other pla form Ceme		10/29	/06	Taneytown	, Maryland
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Ž D	death a atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1⊡Live b 4⊡Pregn	inth 2 ☐ Feta ant at time of d	ıl death 3□	Ectopic pregnancy Other (specify)	у			23d. Date of d Month	Day Year
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	5		30. Name and address of person with									
			Joanne L. Kinne				ch Stree	et, Da	amascu	ıs, Mar	yland 20	0872
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			For State Registrar	State of N	Marylar	-			ealth a Death	and M		giene Reg. No.	UUb	35	516
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	/Medic Examin	er	Avlynne Carey 4a. Facility Name (If not institution, giv	e street and numbe					Location o	of Death	OC CODE	4c.	County of Dea	th	
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	Director	}	578-05-2361 Usual Residence of Decedent	□м 2√Д F		101 Yrs.				1			1905 W		ton, Do
	yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10d. Inside (	
	8a-f e	Director	Maryland Montgo	nery	S	ilver	_							<u> </u>	s 2x No
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960	72 hours after death with the Marylar naturel; or iteme 23s or 28s-1 show iteal Examinar must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Tes 2 If Yes, Give Year or Date	oN <b>≰</b>				Specify:	, , , , , , , , , , , , , , , , , , , ,	, 0.0.,		Specify: Wh		
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aryli	should nd Men marke umatic	To.	19a. Informant's Name/Relationship (			19b. Maili	ng Addre	ss (Street a			ie Mae   Route Numbe		r Town, State, .	Zip Code) 2	0906
Ž	and 2 salth a n 27 is		Linda G. Eisensta 20a. Method of Disposition	dt/Grand	daught	ter 1	5004.	Hunte	er Mo	unta	in-Lane	, Si	lver S	oring.	MD
Baltimore, Maryland	permit. Pages 1 Department of H Importent: if iter any injury or oth		20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Special Control of the Con	Removal from Sta	te (	Place of Dispo cemetery, cre • Olive	matory of	otner place	θ) ; <b>(</b>	Octob	per 28				
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P.O. E	thet the death ed by the ette detached for	hysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnan 9□ Unknow		death 5[	Other (	specify)					MONIN	Day	1641
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Division of Vital Records,	has has	Completed									24a. Was autop perfo 1 Yes		death?	utopsy findings completion of 2 No	s available cause of
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	To the Within To the	Me	29b. Signature and title of certifier	- (	7).		2	9c. License	number			29d. Dat	te signed (Mani	th, Day, Year)	
	12		A CONTRACTOR	Duck	X CA	RD	<	20	59	P08	6	CTO	852	23 20	06
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	Sta Registr		31. Date filed (Month, Day, Year)	0	strar's Sign	ature :	bert	9	-	-			1 4.17		

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2006 Month **Physician** Carl 25, Raymond Helmick, Sr. Oct. 12:30 A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 312 W. Liberty St. Oakland Garrett If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1⊠M 2□F 219-34-7194 68 Director 9/4/1938 Maryland Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director Yes 2 No MD Garrett Oakland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 312 W. Liberty St. 21550 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Amed Folces? 1 □ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 X Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ges 1 and 2 should be filed within it of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Coal Mining Electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Carl \_\_\_\_ Helmick Ruth Shirley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronda S. Hinebaugh/Daughter 83 Sjady Lane, Oakland, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State uit. Pages 1 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Omega Crematory 11/2/06 1 4 ☐ Donation 5 ☐ Other (Specify) Morgantown, WV 21. Signature of Funefa 22. Name and Address of Facility 32 S. Second St. Stewart Funeral Home Oakland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit The law requires that the death certificate be executed Box 68760 attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 4☐Pregnant at time of death Records, P.O. the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an certificate 1 ☐ Yes 2 No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. scribe how injury occurred Certification: After Division To the Hospitei or Attending Natural 2 Accident 5 Pending death. 1 Yes 2 No investigation after death in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel ( Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a. Certifier and manner stated. of person who completed cause of death (Item 23a) (Type, Print) gaway oahland, ud 21550 13079 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of	Maryland / Dep <i>Ce</i>	ertificate of			giene Reg. No.	2006	355	518
I			1. Decedent's Name (First, Middle	, Last)				2. Date of De Month	aath Day	Yeer	3. Time of	Death
	Physici /Medio		SANDRA LEE HIG	DON				остовен	,	2006	1635	М
7	Examir		4a. Facility Name (If not institution	, give street and numb	er)	4b. City, Town, o	r Location of D	Death	4c. C	County of Death	1	
			15720 FAIRHAVE			GOLDSBOR		Hea I		ROLINE		
L	Funeral Director		5. Social Security Number 214-46-4722	6. Sex 1 □ M 2 ▼ F	Age (In yrs. last birthday  58  Yrs.	Months Days		Min. 8. Date of Bir (Month, Da 01/08/	ay, Year)		nplace (State or untry)	r Foreign
	and **		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	ocation					10d. Inside Cit	tv Limits
	death with the Maryland me 23a or 28a-f ehow rmust be notified at	5	MD CAROL	CNIE							1 🗆 Yes	9.5
	28a-	Director	10e, Street and Number	LNE	GOLDSBORG	10f. Zip Code			10a. Citiz	en of What Cou		
	3a or		15720 PATDUAVE	T ANTE								
	me 2	Funeral	15720 FAIRHAVEI	12, Was Decede		21636 Was Decedent of H	ispanic Origin	? (Specify Yes or No	USA - 1	4. Race - Amer	ican Indian,	
9	after or its	Ē	1 ☐ Never Married 2 🛣 Marr			If Yes, specify Cuba		Puerto Rican, etc.)		Black, White	, etc.	
<u> </u>	Pel', c	ρ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	es:	1 ☐ Yes 2X No	Specify:		5	Specify: WH	ITE	
2	within 72 hours after ene. then "neturel", or ite	Completed	15. Decedent (Specify only highes	's Education	16a. Dec	edent's Usual Occup	ation during most of	f working	16b. Kin	d of Business/l		*****
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2	filed w Hygier other th		12		LEGA	L ADVOCAT				NSELING		
and and	be fi	a	17. Father's Name (First, Middle,					Name (First, Middle		Sumame)		
ž	should be filed within 72 hours after death with the Marylan and Mental Hygiene. In marked other than "neturel", or Reme 23a or 28a-f ehow umatic event, the Medical Examinar must be colified at	٢	CHARLES E. JEWI		400 14			E. SKINNER				
, Maryland 21215-0036	12 de la		19a. Informant's Name/Relationsl VERNON LEE HIG					D, CENTRE				
Baltimore,	of H of H rot		20a. Method of Disposition  1 ☐ Burial 2 MacCremation  4 ☐ Donation 5 ☐ Other (S)			osition (Name of ematory or other place KE CREMAT		Date 0-28-2006		ation - City or T		
Baltii	permit. Pag Department Importent: I any Injury o		21. Signature of Funeral Service		CENTER,	22. Name and Addre	ss of Facility FENBET	N & NEWNA	M FUN	ERAL HO	OME, P.	Α.
	20240		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau	sed the death. Do not en	08 S. LIBE nter the mode of dyin	RTY ST g, such as ca	CENTRE rdiac or respiratory a	VILLE rrest,	, MD 21	Approximate Interval Betw	) WB00
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a CHRO	MIC OBS as a consequence of):	TRUCTIV	E Pu	LMONARY	DI	3EAS E	Onset and D	eath
п	Examiner			Due to (or	as a consequence of):	MENT	4 M D	HV/e 10 A	22			
	100	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequence of):	ADISIOI	ZMP	175 EIVE				
	death certificate be executed e attending physician and of for use as the burlal-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	c								
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ROX	attenc attenc for us	lan	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pregnancy			23	3d. Date of delive Month	,	'ear
o.		Physician/Me	1 ☐ Yes 2 € No 9 ☐ Unknown	9□ Unknow		Other (specify)						
2	2 0 0 E	y Ph	Part II. Other significant condition	ns contributing to deat	h but not resulting in the	underlying cause givi	en in Part I.	23e. Did t	obacco us	e contribute to	the cause of de	eath?
g.	uires n sign	d by	HYPERT	NSFON				1.	Yes 2 □	No 3□Pro	bably 4 🗆 U	nknown
ဂ္ဂ	w requ	ete	CHRONIC	- IZA-CK	PATN			24a. Was	an	24b Were aut	opsy findings a	available
Vital Records,	0 - 0	Completed							rmed?	prior to co death?	ompletion of ca	iuse of
<u>e</u>	ilcian: Th certificate rector, pag	0	25. Was case referred to medical	7/1		S-10	26 Place of	☐ 1☐ Yes  Death Check only of	1	1 🗆 Yes	2 LI No	
		To B	examiner? 1 ☐ Yes 2 ❷ No	Hospital: 1   Inp	atient 2 ER/Outpatie	ent 3 DOA Oth		ng Home 5 Resi		□Other (Spec	(hr)	
0	g Physical dispersal di		27. Manner of Death	28a. Date of I			10181	28d. Describe			•97	
ō	Attending I ir death. ector: After by the funer	ate	1 ■Natural 5 □ Pending 2 □ Accident investig	9	Day reary injury		Yes 2 □ No					
DIVISION	l or Atter de Directo	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ned 286. Place of	Injury - At home, farm, s etc. (Specify)	treet, factory, office		28f. Location ( City or To	Street and wn, State)	Number or Rur	al Route Numb	<b>)θ</b> Γ,
	oltal c urs af ral D	Ce										
	ne Hospital on 24 hours at the Funeral Dietely filled i	edical	(Check only 2 Medical I	g Physician To the basi Examiner: On the basi and manner	ist of my knowledge, dea s of examination and/or i stated.	th occurred at the tin nvestigation, in my o	ne, date and p pinion, death o	place, and due to the occurred at the time,	date and p	place, and due	stated. to the cause(s)	
	To the within 2 To the complet	×	29b. Signature and title of certifier			29c. License		110		signed (Month,		
			Enick.	Os) Just	m.D	D	3504	73	10/	26/2	2006	<i>,</i> >
5	Ec		30. Name and address of person	who mpleted calle	of death (Item 23a) (Type	, Print)	CENTROP	OTTIE MIN	2161	7		
7	B		ERIC F.CIGAN			AVENUE,	CENTKE,	VILLE, MD	2101	•		
	Sta Registr		31. Date filed (Month, Day, Year)  OCT		istrar's Signature	frank .	i					

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 2 0 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 18 2006 10:00A Lewis N. Horton October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4303 Delmar Ave. Temple Hills Prince George's If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F VIS Director 238-36-3962 82 Oct. 4, 1924 North Carolina Usual Residence of Decedent with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits r then "natural", or items 23a or 28a-f ehow the Medical Examinar must be nutified at 1 Yes 2 No Director Maryland Prince George's Temple Hills 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 20748 4303 Delmar Ave. United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Maritat Status Black, White etc. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned African 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify à 3 Widowed 4 □ Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) 12th Pages 1 and 2 should be filed w tment of Health and Mental Hygie tant: If tiem 27 is marked other ti jury or other traumatic event, III Auto Body Mechanic Self-Employed Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Hollace Horton Minnie Robertson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any injury or other trau 4303 Delmar Ave., Temple Hills, MD Evangeline M. Gregory/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 10/24/2006 Brentwood, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., NE Wash., DC 20019 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part1 Immediate Cause (Final disease or condition resulting in death) PROSTATE **Physician** CARCINOMA VEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 by Physician/Medicai ettending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown φ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan autopsy 2 No 1 ☐ Yes Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification; 5 Pending investigation 1 X Natural death. 2 Accident Director: d in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide within 24 hours a To the Funerel I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) DO0 5916 OCTOBER, 24, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PILI

DHMH 17 Rev 1/2001

State Registrar 120 BENTO

JOHNS HOPKINS HOSPITH 401 N. BROADVIEW BALTIMORE NO

			For State Registrar	State of Ma	aryland / Dep Ce	artment of artificate o		Mental Hy	giene 0 (	)6 355	20	
			1. Decedent's Name (First, Middle, La	st)				2. Date of De		3. Time of De	eath	
	Physici /Medic		ELSIE	V. HII	L			OCT.	19, 20	06 11:40	A	
	Examin		4a. Facility Name (If not institution, giv	e street and number)			, or Location of Dea		4c. County of	Death		
			Holy Cross I				er Sprin			NTGOMERY		
	Funeral		5. Social Security Number 6. S	Sex 7.Aga I□M 2.ScF	e (In yrs. last birthday Yrs.	Months Day	ar If Under 24 Hrs	. (Month, Da	ay, Year)	Birthplace (State or Fo Country)		
	Director		220-50-7832   Usual Residence of Decedent	- A	60 ""			June	8,1946	Maryland		
	land ow		10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City L	Limits	
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	r 288	Director	10e. Street and Number	-		10f. Zip Code	•		10g. Citizen of Wh	nat Country?		
	h with		3824 Gawayne	e Terrace	<u> </u>		20906	5	U	.S.A.		
	within 72 hours after deeth with the Maryland ene. then "nature!", or Iteme 23e or 28e-f ehow the Mudical Exercities coval be notified at	Funeral	11. Marital Status	12. Was Decedent   Armed Forces?		Was Decedent o	f Hispanic Origin? ( uban, Mexican, Pue	Specify Yes or No	o- 14. Race	- American Indian, White, etc.		
9	or h		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☑ N	No	1 Yes 30 N		no moun, en.,	Specify:			
93	ure!,	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:		103 103 103	о ороску.		зресну.	Specify: Black		
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70	Hygie ther	ပိ	12th  17. Father's Name (First, Middle, Last	)	App.	.1Cat10	n Examir		U.S. I	Governmen	L	
an	d be ental ced o	o Be	Robert John:						h Powel			
<u> </u>	shoul mari	은	19a. Informant's Name/Relationship (		19b. Mai	ing Address (Stre	et and Number or F					
N N	nd 2 lith e 27 le r treu		Christine Wils	son (Dauc	hter) ]	.8532 B	rooke Ro	l. Sand	y Sprin	g, MD 208	60	
ā,	s 1 ar		20a. Method of Disposition		20b. Place of Disp cemetery, cri			Date		ity or Town, State		
Ę	Pege lant o nt: If ry or		1 urial 2 Cremation 3 4	Removal from State				/26/06	Sandy	Spring, M	D	
Baltimore, Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Importent: If Item 27 Ie marked other then "naturel", or Iteme 23a or 28a-1 ehow with fujury or other treumatic event, the Mucical Example in malk to notified at ance.		21 Signature of Funeral Service Lice							L HOME, P		
Pm	88 - 8		CEME K	· Date	Malle	46 N.	Washingt	on St,	Rockvil	le,MD 208	50	
			23a. Part1. Enter the disease, or com shock, or heart allure. List only	plications that caused	I the death. Do not en	nter the mode of d	lying, such as cardia	ac or respiratory a	rrest,	Approximate Interval Between	en	
	Physician		Immediate Cause (Final disease or condition							Onset and Dea		
	/Medical		resulting in death)	Due to (or as	Lomyopath a consequence of):	1У						
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-	p #	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underrying Cause (Disease or injury	Due to (or as	a consequence of):							
	cate be executed physiclen and tha burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of);							
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687	icate phys s tha	dicai		_ d								
	daath certifice ettending ph d for use as tl	/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date	of delivery		
B	daath etter d for u	clar	in the past 12 months? 1 □ Yes 2 No	1 ☐Live birth 4 ☐ Pregnant at		□Ectopic pregnar □ Other (specify)			Mont	,	ar	
O	that tha da ned by tha e detached f	hysi	9 Unknown	9□ Unknown								
Division of Vital Records, P.O. Box	res that igned b	by Physician/Me	Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause	given in Part I.	23e. Did	tobacco use contrib	ute to the cause of deat	.th?	
rd	w require been sig should b							10	Yes 2 □ No 3	Probably 4 🔀 Inki	rnown	
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ital	ysician: The l is cartificate he director, paga	Bec	25. Was case referred to medical		***		26. Place of De	ath (Check only	^	1103 20110		
>	Physic this ca al direc	To	examiner? 1 ☐ Yes 2√∑ No	Hospital: 1 ☑ Inpatie	ent 2 ER/Outpatio	ent 3 DOA	Other: 4 Nursing	Horne 5 ☐ Res	idence 6 Other	(Specify)		
0	ng Pl		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Time	of 28c. In	jury at vork?	28d. Describe	how injury occurred	J		
sio	endin eath. or: A	catle	2 ☐ Accident investigatio	n			□Yes 2□No					
Ξ̈́	lor Att after d Direct	Certification;	3 Suicide 6 Could not be determined		ury - At home, farm, s c. (Specify)	treet, factory, offic	ee .		Street and Number wn, State)	or Rural Route Number	r,	
	ospital of hours at numerel Distriction is tilled in the contract of the contr											
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	6	8	20 Name and address f	omploised as	looth (lis= 22=) T		0 6248		10/17	106		
			30. Name and address of person who Prathima Pat				len Rd.	er Spring.MD 20910				
	Sta	te	31. Date filed (Month, Day, Year)		ar's Signaturo	- rest		,	_ ~ [	,, 2051		
	Registr	_	OCT 2 4 2	006	. K. B	rade						

DHMH 17 Rev 1/2001

	-	For State Registrar	State of M	aryland		artment <i>tificate</i>			nd Me	_	giene Reg. No.	2006		35521	
Physicia	_	Decedent's Name (First, Middle, Last     MICHAEL ORVILL		HER	RON				2	2. Date of De Month OCTOBE	ath			3. Time of Death 9:00A M	
/Medic Examine	_	4a. Facility Name (If not institution, give	street and number)			•		Location of	Death		4c.	County of Dea			
Funeral Director		5. Social Security Number 6. S 409-68-2557		je (In yrs. la 65	ast birthday) Yrs.	If Under 1		If Under 2 Hours	Min.	B. Date of Bird (Month, Da MAY 27	y, Year)	C	rthplac ou <i>ntry</i> NNES		
Maryland f show		Usual Residence of Decedent  10a. State 10b. County  MARYLAND MONTGOM	ERY		, Town or Lo								10d	tnside City Limits 1 ☐ Yes 2 ☒ No	_
h with the 23a or 28a	<u> </u>	10e. Street and Number 12511 CONNECTICUT A	VE			10f. Zip (	209	06			_	zen of What C			-
iore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland to I Health and Mental Hygiene. If item 27 ie marked other than "natural", or items 23e or 28e-f show or other traumatic event, the Madical Examinar wat be notified at	by Fur	11. Marital Status 1 ☐ Never Married 2፟ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1  Yes 2 1 If Yes, Give Year or Dates:	)	1	Was Decede If Yes, specif 1 ☐ Yes 2	fy Cuba	spanic Orig n, Mexican, Specify:	in? (Speci Puerto Ri	fy Yes or No ican, etc.)		I4. Race - Am Black, Wh Specify: AME	ite, etc		
more, Maryland 21215-0036  Pages 1 and 2 should be filed within 72 hours af nent of Health and Mental Hygiene.  Interest if item 27 is marked other than "natural", or riv or other traumatic event, the Madical Exam	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		5+)	(Give life.	dent's Usual kind of work DO NOT use	k done d e retired,	luring most )	of working	7		ond of Business ONAUTICS SYSTEM	ANI	-	
aryland 2 should be filed and Mental Hygi marked other umatic event,	To Be Co	17. Father's Name (First, Middle, Last) DANIEL HERRON			COL	a OILK E	JILOI	18. Mother	r's Name (	First, Middle,	Maiden	Sumame)			
e, Mar 1 and 2 sho Health and em 27 le m ther traum				20h Pi	12511	CONNEC	CTICU			ER SPRI	NG, M	Town, State, D 20906 cation - City o			
E. 8 5 5 5		GWENDOLYN M. HERRON - WIFE  20a. Method of Disposition  1							10/26/	2006	BRE	NTWOOD,	MARY	LAND	
Balti permit. F Departm Importar ony inju		23a. Part Enter the disease, or com		d the death	1	1800 NE	EW HA	MPSHIR	E AVE.	SILVER	SPRI		2090		
Pnysician /Medical Examiner		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.   RESPIRATORY FAILURE  Due to (or as a consequence of):  METASTATIC CANCER OF COLON  Sequentially list conditions,											le:	terval Between nset and Death	70
I Records, P.O. Box 68760,  The lew requires that the dean certificate be executed at has been signed by the attending physicien and bage 2 should be detached to use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c												
P.O. BOX 68 that the death certificated by the attending placement of use as the detached for use as t	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pre Other (spe					2	23d. Date of de Month	elivery Da	y Year	
cords, P.	2	Part II. Other significant conditions of DIABETES TYPE 2	contributing to death t	out not resu	ulting in the u	nderlying ca	iuse give	on in Part I.						cause of death?	
I Recor	Completed									24a. Was autop perfo	osy rmed?	24b. Were a prior to death?	comp	findings available letion of cause of	
0 4 - 0	tion: To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 🖾 No  27. Manner of Death  1 ☒ Naturat 5 ☐ Pending investigation	28a. Date of Inju (Month, Da	ury	ER/Outpatier 28b. Time o Injury		Bc. Injury Work	ar: 4 □ Nur	rsing Homo	Check only of the State of the	dence 6	Other (Sp	ecify)		_
Division  To the Hospital or Attending within 24 hours effer death.  To the Funeral Director: After completely filled in by the funer	Certification	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of In	jury - At ho tc. (Specify	me, farm, str					f. Location ( City or To		d Number or F	Rural F	oute Number,	
To the Hospital within 24 hours of To the Funeral I completely filled	edicai	(Check only 2 Medical Examone)	nysician: To the best niner: On the basis of and manner st	of examinal		vestigation,	in my op	oinion, deat			date and	place, and du	e to th	e cause(s)	
D Việt 7	Σ	29b. Signature and title of certifier	2 Open and a second	5	220\ /T			006023	3			e signed (Mor			
		30. Name and address of person who DR NAN WANG 1  31. Date filed (Month, Day, Year)	.0810 CONNECT	CICUT A	VE, K	ENSING	CON,	MD 2089	95						
Sta Registr	1	OCT 2 4 2	006 32 Aegist	iais signa	ture day	and									

		1 = For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of H ertificate of L	ealth and M D <i>eath</i>		ene2006	35522
Physic	cian	Decedent's Name (First, Middle	•				2. Date of Death Month	Day Year	3. Time of Death
/Med				s Harris		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Oct	20, 2006	12:15 P
Exam	iner	4a. Facility Name (If not institution				Location of Death	l.	4c. County of Deat	
		5. Social Security Number	unty Nursing Cent	er e (In yrs. last birthday		ince Frederic			holace (State or Foreign
Funera Directo		213-40-6388 Usuel Residence of Decedent	1 X M 2□ F	80 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Feb 22,		hplace (State or Foreign untry) Maryland
ryland how		10a. State 10b. County		10c. City, Town or L	ocation	·			10d. Inside City Limits
e Ma	cto	MD	Calvert			Lusby			1 ☐ Yes 2 No
라 라 or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	-
ath w	<u>ea</u>	325 Planters Wharf R				20657		U.S	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Exactinar must be motified at	by Funeral	11. Marital Status  1 Never Married 2 Married	ff Yes, Give		. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🕱 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Bla	e. etc.
2 hours atural:	ted b	3 ☑ Widowed 4 □ Divorced  15. Decedent	Year or Dates:	16a. Dece	edent's Usual Occupa	ation	1	6b. Kind of Business/	
ed within 72 hours aft giene. Inthen "natural", or t, tre Medical Exeral	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4or 5	i+) life.	e kind of work done of DO NOT use retired Bric	klayer	mry	Mas	onrv
Hygie ther	ပိ	6 17. Father's Name (First, Middle,	Last)		Bile		e (First, Middle, M		,
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nd 2 should be file Ith and Mental Hy 27 is marked oth r traumatic avant	ုင	19a. Informant's Name/Relationsl			ling Address (Street a	and Number or Run		City or Town, State, 2	Zip Code)
d 2 s th an 17 te trau		LaShawn Brooks/da			Planters Wha			-	,
Heal Heal		20a. Method of Disposition	3	20b. Place of Disc	position (Name of			Oc. Location - City or	Town, State
Pages ment of ent: If i		1 ⊠ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)			ematory`or other plac Vestern Cemetel	10	/26/06	Prince Fre	derick, MD
permit. Pages 1 ar Depertment of Hea Importent: If item any injury or othe		21. Signature of Funeral Service	a Sewel 6	2		uneral Home	ad Prince E	rederick, MD 20	1678
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uires that the signed by the	á	Part fl. Other significant condition	ons contributing to death b	ut not resulting in the	underlying cause give	en in Part I.	23e. Did tob 1 ☐ Ye	acco use contribute to s 2 No 3 □ Pr	o the cause of death? obably 4 Unknown
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is certificat director, p	Be	25. Was case referred to medical examiner?				26. Place of Deal	h (Check only one	9)	
Physician: this certific	P P	1 ☐ Yes 2 🛪 🐪	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpati		4 Nursing Ho	ome 5 Reside	nce 6 ☐Other (Spe	cify)
Attending PI r death. actor: After th by the funera		27. Manner of Death  1 Naturaf 5 Pendin 2 Accident investig			Worl	yat k? Yes 2 □No	28d. Describe ho	w injury occurred	
or Attending after death. I Diractor: Afte	Certification:	3 Suicide 6 Could 4 Homicide determ	ined 288. Place of In	jury - At home, farm, s c. (Specify)	street, factory, office	,	28f. Location (Str City or Town	reet and Number or Ri , State)	ural Route Number.
Hospite 4 hours Funaral ely fillec	edical C	29a. Certifier (Check only one)  Certifyin 2 Medical	g Physician: To the best Examiner: On the basis of and manner st	f examination and/or	ath occurred at the tin investigation, in my o	ne, date and place, pinion, death occur	and due to the ca red at the time, da	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
To the Within 2 To the complet	Me	29b. Signature and title of certifie			29c. Licens	e number	29	d. Date signed (Mont	h, Day, Year)
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.5		30. Name and address of person	was completed cause of o	death (Item 23a) (Type	e. Print)	7/0	12	Fre	che MO 20
	State	31. Date filed (Month, Day, Year)	32. Registi	Pallall n rags Signature	110 HOS	of the Re	a //inc	CI / Edla	rece "12 Le
Regis		net	2 4 2006	Weener H.	Sneet!				

			1 - State Registrar  1. Decedent's Name (First, Middle, Last)	State of Maryla	and / Depa	artment o	f Health an of Death	2. Date of De	Reg. No. ath	3. Time of Death
	Physici /Medi			Jane H	larris			Month	ct 20, 2006	9:30 A M
	Examir		4a. Facility Name (If not institution, give st 309 Wood He			4b. City, Tow	n, or Location of D Annapol	s		of Death Anne Arundel
	Funeral Director		5. Social Security Number 226-76-2373 6. Sex Usual Residence of Decedent	1 oM c	vrs. last birthday) 5 Yrs.	If Under 1 Your Months Da		Ain (Month, Da	th ly, Year) 5, 1951	9. Birthplace (State or Foreign Country) Japan
	Maryland	tor	10a. State 10b. County  MD Anne Art		City, Town or Lo	ocation	Annapol	is		10d. Inside City Limits 1 ☐ Yes 2 📉 No
	h with the 23a or 28a st be not	al Direc	10e. Street and Number 309 Wood Hollow Court			10f. Zip Cod	<sup>de</sup> 21409		10g. Citizen of V	Vhat Country? U.S.A.
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be notified at ance.	Completed by Funeral Director	11. Marital Status 12 1 Never Married 2 Marned 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ∏Yes 2 X No If Yes, Give Year or Dates:		Was Decedent If Yes, specify (		? (Specify Yes or No uerto Rican, etc.)		e - American Indian, ck, White, etc. c: Japanese
Maryland 21215-0036	I within 72 ho lene. r then "natur the Medical	ompleted	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Oo kind of work do DO NOT use re	one during most of	working		spresso Bar
yland	ould be filed Mental Hyg arked other	To Be C	17. Father's Name (First, Middle, Last)	okuo Kurosaka			18. Mother's	Name (First, Middle, A	Maiden Sumam iko Ishizuk	
, Mar	and 2 sho saith and n 27 is m er traum		19a. Informant's Name/Relationship (Type Arthur Harris/son	e, Print)				r Rural Route Number urchton, MD 2		State, Zip Code)
Baltimore,	Pages 1 ment of He ant: if iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ⚠ Cremation 3 ☒ Re 4 ☐ Donation 5 ☐ Other (Specify)			osition (Name of matory or other litan Crema	place)	Date 10/21/06	Al	City or Town, State exandria, VA
Balt	permit. Departimport any inj		21. Signature of Fundral Service Licenset	Zewell	,	2. Name and Ad	ddress of Facility	eal Hom	E Prince	DARES BEACH Rel E Fred, MD 20678
-	Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the discusse on each line.  OVAVIAA  Due to (or as a constant)	Cano	ter the mode of	dying, such as car	diac or respiratory a	rrest,	Approximate Interval Between Onset and Death  O mun ths
	fficate be executed g physicien and as the burial-transit	ilcal Examiner	Sequentially liss conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a cons						
Division of Vital Records, P.O. Box 68	ath cert	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 N No 9 □ Unknowr	c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3	□Ectopic pregna □ Other (specify			23d. Dat Mor	e of delivery nth Day Year
rds, P	quires that the de in signed by the a uld be detached f	þ	Part II. Other significant conditions contri	ibuting to death but not	resulting in the u	inderlying cause	e given in Part I.		obacco use contr res 2 □ No	ribute to the cause of death?
al Reco		Completed						24a. Was autor perfo 1 Yes	rmed?	Nere autopsy findings available prior to completion of cause of leath?  Yes 2 No
<u>=====================================</u>	sician certifi rector	Be	25. Was case referred to medical examiner?	spital:			Other	Death (Check only o		
ō	Phys r this aral di	<u>٦</u>	1 Yes 2 No	28a. Date of Injury	2 ER/Outpatier 28b. Time o		4 □ Nursin	g Home 5 Resident	dence 6 Other	
sion	Attending Physician: r death. ector: After this certific by the funeral director.	catlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day Year	r) Injury		Work? 1 ☐ Yes 2 ☐ No			
<u>N</u>	i di di	Certification;	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	ecify)	•		City or Tox	vn, State)	er or Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in In	Medical	29a. Certifier 1 ☑ Certifying Physic (Check only one) 2 ☐ Medical Examine	cian: To the best of my er: On the basis of exam and manner stated.	knowledge, deat nination and/or in	h occurred at th vestigation, in r	e time, date and pl ny opinion, death o	ace, and due to the courred at the time,	cause(s) and ma date and place, a	nner as stated. and due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier    Season   Season	ers mr	)	29c. Lic	cense number		29d. Date signed	(Month, Day, Year)
**	ID		30. Name and address of person who com	pleted cause of death (I	Item 23a) (Type,	Print)	N #300	4.	21/18	(Month, Day, Year)  1 (Zu), 2006  2190
	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Registra's Si	gnature	Brask		1 nnews	JULI JU	12 (170)

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JANE HARRIS

	,		For State Registrer	State of Maryland / [	Department of H Certificate of I			2006	35524
	Physicia	an	Decedent's Name (First, Middle, Last)	Nelson Hostette	r		2. Date of Death Month October	Day 2006	3. Time of Death 4:20 A. M
	/Medic Examin	_	4a. Facility Name (If not institution, give	street and number)		Location of Death		4c. County of Death Washingto	on
	Funeral Director		5. Social Security Number 6. Sec. 15	to acres	Yrs. If Under 1 Year Months Days	Hours Min	8. Date of Birth (Month, Day, Y July 15 ]	ear) 9. Birthp Cour 1945 Mary	
	ס		Usual Residence of Decedent  10a. State  10b. County	10c. City, Tow				1	0d. Inside City Limits 1 ☐ Yes 2 📉 No
	with the M. I or 28a-1 Le nutifie	Director	MD. Washingt  10e. Street and Number  20449 Lehmans Mil		erstown 10f. Zip Code 2174	. 2		. Citizen of What Cour	
39	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show entry injury or other traumatic event. The Medical Examination is notified at ODGs.	by Funerai		12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba			14. Race - Americ Black, White,	
Maryland 21215-0036	within 72 houiene iene "nature rthan "nature ire Medice E	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired Farmer	ation during most of workin t)	g	b. Kind of Business/In	
land ?	uld be filed fental Hyg rked other tic event,	To Be C	17. Father's Name (First, Middle, Last)	s Hostetter		18. Mother's Name Ethel M		iden Sumame)	
, Mary	and 2 shoralth and N		19a. Informant's Name/Relationship (Ty Miriam L. Hostet		. Mailing Address (Street a 20449 Lehman	ns Mill Rd	. Hagers	town, Md.	21742
altimore,	Pages 1 and nent of He ant: If Item		20a. Method of Disposition  1 ⊠ Burial 2 □ Cremation 3 □ F  1 □ Donation 5 □ Other (Specify)	20b. Place of Miller Church	of Disposition (Name of any, crematory or other place is Mennonite Cemetery	11/1/	06 L	c. Location - City or To eitersburg	, Md.
Balt	permit. Departi Import. eny inj		21. Signature of Funeral Service Licens	unneemin O-		45 S. Carl	lisle St.	and Son Fur Greencast	le, Pa.
13	whysician and white buriat-transit	Examiner	23a. Part1. Enter the disease, or compishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence  Due to (or as a consequence  Due to (or as a consequence  Due to (or as a consequence	of):		respiratory arres		Approximate Interval Between Onset and Death
P.O. Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Medical E	in the past 12 months?  1 Yes 2 No 9 Unknown	d	5 Other (specify)		22a Did taba	23d. Date of deliver Month	Day Year
ords,	w requires the been signed should be do	ted by	Part II. Other significant conditions co	ntributing to death but not resulting	in the underlying cause giv	en in Parti.		1	pably 4 Dunknown
I Rec	The law a	Completed					24a. Was an autopsy performe	prior to co	opsy findings available impletion of cause of
Vita	Physician: r this certitics ral director, r	Be	25. Was case referred to medical examiner?	Hospital:	utnationt 3 DOA Oth	26. Place of Death		C [] (Mary (Green)	
n of	ing Phys After this uneral di	lon: To	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury 28b.	Time of 28c. Injur	y at 2	28d. Describe how	ce 6  □Other (Specii injury occurred	9/)
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, f building, etc. (Specify)			28f. Location (Stre City or Town,	et and Number or Rura State)	al Route Number,
_	To the Hospital within 24 hours a To the Funeral I completely tilled	edical C	29a. Certifier 1 Certifying Phyone) Check only 2 Medicel Exem	sicien: To the best of my knowledg iner: On the basis of examination a and manner stated.	e, death occurred at the tir nd/or investigation, in my o	me, date and place, a pinion, death occurre	and due to the cau ad at the time, date	se(s) and manner as s e and place, and due to	stated. o the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	n-	29c. Licens			Date signed (Month,	Day, Year)
	4		30. Name and address of person who c		(Type, Print) 04, Shad	043466 E	Pa 1-	7256	
	Sta Regist		31. Date filed (Month, Day, Year)	32, Registrar's Signature	Anadas			4	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1- State Registrar Amend # 4a,5,10e,10f per phy Electrificate of Death 10-31-2006, No. CNM 2 Date of Death 3. Time of Death 7:40 p<sub>M</sub> 1. Decedent's Name (First, Middle, Last) OMT 23/2006 Physician ELIZABETH ANN HARRIS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Facility Name (it not institution, give state 1 = 639 West Adams Circle Examiner Woodsboro If Under 1 Year | If Under 24 Hrs. 5. Social Security Number (In yrs. last birthday) 8. Date of Birth (Month Pay Year) 6-17-1926 9. Birthplace (State or Foreign Age (I. **Funeral** Days Hours 324-20-5599 1 M 2 XF Illinois Director Vrs Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits i Hygiene. other then "natural", or Itema 23a or 28a-f show vent, tre Medical Exercitest must be notified at Woodsboro MD Frederick 1 Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 639 West Adams Circle 21798 21163 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give A Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours atternent of Health and Mental Hygiene.
nt: if item 27 is marked other then "natural; or ite
ary or other traumatic event, Itta Madical Examina 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 College (1-4or 5+) Elementary/Secondary (0-12) Md. State Government Receptionist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fairey Collins Harold Eggerman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 7177 Brown's Lane Thurmont, Md. 21788 19a. Informant's Name/Relationship (Type, Print) Mrs. Jo Ann Brown/Daughter 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Competery, Cromatory of other place)
Smithsburg Crematory 10/26/06 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Smithsburg, Maryland Department of Important: if eny injury or once. 22. Name and Address of Facility ROBERT E. DAILEY & SON, FUNERAL HOMES, P.A. 615 E. Main St. Thurmont, Maryland 21788 21. Signature of FunerallS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Candiovascular Atherosclesofic **Physician** 20 / enas /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transit Exami resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown ے Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 3 Probably 4 Unknown 1 ∏Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 autopsy performed? (es 2 2 No 1 Yes 1 Yes 2 No ivision of Vital After this certification funeral director, p Attending Physician: Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) Certification: To 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation the 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by within 24 hours after or To the Funeral Direct completely filled in by 4 \ Homicide ŏ Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00035152 10.2506

Registrar

State

5. Center ST

Thun mond MA

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32. Resistrar's Signature

100

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

RONTZ

31. Date filed (Month pay

State of Maryland / Department of Health and Mental Hygiene UU 6

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year REEMAN 10 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAITIMORE UNIVERSITY OF MARY LAND MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 76 Days Hours 1**⊠** M 2□ F Director Yrs. 390-28-6794 WI Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show ir than "natural", or items 23a or 28e-f shov The Medical Examiner must be notified at FLSarasota Osprey 1 ☐ Yes 2 🔼 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 817 Oak Briar Lane 34229 USA by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1XIYes 2 □ No If Yes, Give Year or Dates: Korea 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 Movidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ and Mental Hygiene. Engineer Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ralph J. Hill 27 is marked r treumatic e Emma Carlson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet J. Hill/Daughter 2302 Canteen Circle, Odenton, MD 21113 item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) Oct. 23, 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: if it any injury or o 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Barrancodd & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final CORDNARY ARTERY DISEASE Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner MYOCARDIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine anding physicien and use es the buriat-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical attending for use es IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 4 Pregnant at time of death P.O. I certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2 No Hospital or Attending Physician: After this certification funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 No 1 Tyes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be determined 3 Suicide To the Hospital or Ati within 24 hours after d To the Funeral Direct Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 61052 OCTOBER 18: 200 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEON VIGILANCE 22 South Greene St., Baltimore, MD 21210 31. Date filed (Month, Day, Year) OCT 2 32. Progistrar's Signature State Registrar

		1 - State Amend #8 Personal Registrar  1. Decedent's Name (First, Middle, Lasi		Ce	rtificate	of D	eath		2. Date of Dea				3. Time of	
Physici		Richard	Franklin	J	nes				Month Octobe	Day		Year )6	4:10	p
/Medio		4a. Facility Name (If not institution, give	street and number)		4b. City, To	wn, or I	Location	of Death	00000	1	County		7.10	
		3222 Henson Ave	nue		Anna	apo1	is					Arur	nde1	
uneral		5, Social Security Number 6. Se	X 7. Ag	ge (In yrs. last birthday)	If Under 1 Months [	Year Days	If Under Hours	Min.	8. Date of Birti (Month, Day	/, rear)		9. Birthp	lace (State o	r For
irector		578-20-9332 Usual Residence of Decedent	CTIAL SCILL	83 Yrs.				I	Feb 26	1933			isy1var	nia
A III		10a, State 10b. County		10c. City, Town or Lo	cation							1	0d. Inside Cit	ty Li
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128a	Director	10e. Street and Number			10f. Zip C	ode				10g. Citiz	zen of W	hat Coun	ntry?	
38.0	0	3222 Henson Avenu	۵			214	กร			II	SA			
Ē	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Deceder			igin? (Spec	cify Yes or No- Rican, etc.)		14. Race		an Indian,	_
naturel', or iteme 23a or 28a-f ehow Jigal Examinar must be notified at	by Fu	1 Never Married 2 Married	1 X Yes 2 □	No	1 ☐ Yes 2 <b>∑</b>		Specify:		110411, 610.7		Specify:	c, White,		
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ਜੂ ਜੂ ਜੂ	8	17. Father's Name (First, Middle, Last)						er's Name	(First, Middle,				, I Inite II t	_
	To B	Burt Jones				м	arv	C1em						
is mar		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Maili	ng Address (S				Route Numbe	r, City or	Town, S	State, Zip	Code)	
if item 27 is marke or other traumatic		Marcella S. Jones	(Wife)	The state of the s			enue	, Ann	apol <b>i</b> s	, MD	214	03		
r oth		20a. Method of Disposition  1 Date  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State												
ant: If its ury or o		1X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Lincoln Memorial  10-27-2006 Suitland, MD											D	
important: if any injury or once.		21. Signature of Funeral Service Coms	ee 4	2:	Name and	Address	of Facili	ty oral	Home,	DΛ				
E = 3		178 4.0		Ü.	12 Ri	ldge	ly A	venue	Anna	poli	s, M	D 21	401	
edical and prize the prize transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Dué to (cr as	a consequence of):  a consequence of):										
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by the ettending parached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	Ectopic preg					2	3d. Date Mont	of delive	,	/ear
igned b be deta		Part II. Other significant conditions co	ntributing to death b	out not resulting in the u	nderlying caus	se giver	n in Part I		23e. Did to	bacco us	se contrib	bute to th	e cause of de	eath
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s peen s	Completed								24a. Was a		24b. W	ere autor	osy findings a	avail
page 2	E		·····						autops	med?	pr de	or to con	npletion of ca	luse
certificel rector, p	0	25. Was case referred to medical					26. Place	of Death	1 ☐ Yes Check only or	2 No	11,	Yes	2   NO	_
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Director: I in by the	ertification;	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At home, farm, str c. (Specify)	eet, lactory, o	ffice		28	Bf. Location (S City or Town		Number	r or Rural	Route Numb	oer,
uneral	edical Ce	29a. Certifier (Check only one) (Check only one)	sicien: To the best ner: On the basis o and manner st	of my knowledge, death	n occurred at restigation, in	the time	, date an nion, dea	nd place, an	nd due to the c	ause(s) a late and p	and man	ner as stand due to	ated. the cause(s)	
To the complet	Me	29b. Signature and title of certifier		)	29c. L	icense	number		2	9d. Date	signed	(Month, L	Dey, Year)	_
F 0		DAM del	1 A	enta wo		7)	2	143		_	- /			07
		30. Name and address of person	mpl te cause of	leath (Item 23a) (Tune	Brint)		g.	. /-	1An AN	(	,	1		
		A. Viene and degrees of being	00030 010	2 m 445	TN""/		. 6		Λ			AA .		

State of Maryland / Department of Health and Mental Hygiene 006 35528 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 9:15 PM October 22, 2006 Dumay Jubuisson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Olney

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months | Days | Hours | Min. | July 31, 19 Montgomery General Hospital Montgomery Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1⊠M 2□F Yrs. Director 133-46-9997 82 Haiti Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits if of Health and Mental Hygiene.
If item 27 is marked other then "naturel", or items 23a or 28a-f ehow or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 1 Yes 21 No Montgomery Maryland Silver Spring Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3909 Littleton Street 20906 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after 1 Never Married 2 Married Specify: Black Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Sales Representative Pharmacy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Thermonfils Jubuisson Maria Lafontant ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3909 Littleton Street, Silver Spring, MD 20906
of Disposition (Name of Date 20c. Location - City or Town, State Suzanne Jubuisson/ Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State October 28 permit. Page Department of Important: if eny injury or once. Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2006 Silver Spring, Maryland 21. Signature of Funeral Service Licensee Prancisdo Socialins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 Marres Ca 23a. Part1. Enter toe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIOPULMONARY FAILURZ DAYS /Medical Due to (or as a consequence of): Examiner PACEMAKED 9601BC BOBH. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): 68760 death certificate be Physician/Medical for use as the Box IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the the detached o 9 Unknown 9 Unknown ٦ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records. page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2□ No 24a Wasan certificate has 1 Yes 2 ₹No Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA ŏ After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation Division 1 PNatural Injury 1 Yes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident the 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Thomicide 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of cortifier 29c. License number 29d. Date signed (Month, Day, Year) OCTOBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (20). CHROX DLNET G= 1 2900 DLNEY WED 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2 6 2006 OCT Registrar

**ORIGINAL** 

B) OK

BOX 23A

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State of Maryland / Dep	artment of H	lealth and Mental	Hygiene2	00	6
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النفائد الم	1	For State Registrar				tificate of	Health and Death		Reg. No.		3332
ysician Medical	1	1. Decedent's Name (First, Middle, Last リいっ	)				Jeon	2. Date of De Month	Day	Year <b>2006</b>	3. Time of Death
aminer eral etor		5. Social Security Number 6. Se	PKins ;	HOS, e (In yrs. 84	Pr-14/ last birthday) Yrs.	4b. City, Town,  If Under 1 Yea  Months Days		ويخا	th ay, Year)		place (State or Foreig ntry) REA
-	-	Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation		DEIT: 30	, 1922		Od. Inside City Limit
tor	2	MARYLAND HOWARD			-	OTT CITY					1√2 Yes 2 □ N
Director		10e. Street and Number				10f. Zip Code			10g. Citizer	of What Cour	ntry?
leted by Funeral Director	oy ruildiai	8740 TOWN AND COUNTRY  11. Marital Status 1  Never Married 2 Married 3 X Widowed 4 Divorced	BLVD APT.  12. Was Decedent E Armed Forces?  1 Yes, Give Year or Dates:	Ever in U		Vas Decedent of Yes, specify Cu		(Specify Yes or No erto Rican, etc.)	)- 14.	H KOREA  Race - Americ Black, White, Decify:  AS	
Completed		15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	+)	1	ent's Usual Occu kind of work done OO NOT use retin	upation ed during most of v	vorking		of Business/In	dustry
Be		17. Father's Name (First, Middle, Last)			110.		18. Mother's N	lame (First, Middle			
2	2	MOON HO JEONG						CHOI			
	1	19a. Informant's Name/Relationship (Ty JAE BYOUNG KANG - SON	рө, Print)					Rural Route Numbe BLVD APT. I			
once.	2	Oa. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		Place of Dispos cemetery, crem	sition (Name of latory or other pla I CREMATOR	ace)	Date 31/06	20c. Locat	ion - City or To	wn, State
once.		21. Signature of Funeral Service License	<del>30</del>					NES - RINAI VE, SILVER			,
Aedical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  c.  Due to (or as a consequence of):										
leted by Physician/Me		F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	2 ☐ Feta	Ideath 3□	Ectopic pregnand Other (specify)	ey .		23d.	Date of delive	ry Day Year
<u>چ</u>		art II. Other significant conditions con	tributing to death bu	t not res	ulting in the un	derlying cause gi	ven in Part I.		obacco use d		e cause of death? ably 4 EtInknown
e Completed		T Western day of								4b. Were autop prior to con death? 1 \( \subseteq \text{Yes}	osy findings available apletion of cause of
ertification; To Be Compl	1	5. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1 Inpatier	t 2 🗆	ER/Outpatient	3□ DOA Ot	hor	eath Check only o		Other (Specific	)
		7. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	,	28b. Time of Injury	28c. Inju		28d. Describe h			,
Certification		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	(Ѕрөсіт)	v) 			28f. Location (S City or Tow	n, State)		
	2	9a. Certifier Certifying Physical Examination one)	ician: To the best of er. On the basis of and manner stat	examina	wledge, death tion and/or inve	occurred at the to estigation, in my	me, date and place opinion, death occ	ce, and due to the courred at the time, or	cause(s) and date and pla	I manner as sta ce, and due to	ated. the cause(s)
edica											
Medical Ce	2	9b. Signature and title of certifier  Mixture E. Bet  O. Name and address of person who con  Nixture E.Berm, The Ti	emy. N	1.0.		29c. Licen:				gned (Month, E K B,	

06-08045 Michael E Jones

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Cert	tificate of	Death		Reg No 200	6 3553
Physici ledical Exami		MICHAEL	Е.		ONES		eath Day Year 25, 2006	3. Time of Death 2345 hrs
12 1		4a Facility Name (if not institution, give street and nur Manor Care Nursing Home	nber)	41	D. City, Town, or Loc Largo	cation of Death	4c. County of Deat Prince Georg	
Funeral		·	7. Age (In yrs. Ia:	st birthday)		If Under 24Hrs. 8. Date of I	Birth (MM/DD/YYYY) 9. Bi	
Director		214-96-9599 1 M 2 F	40	Yrs.	Months Days	Hours Min.		ountry)
any		10a. State 10b. County	10c. City,	Town or Locatio	n			10d Inside City Limits
Maryland 28a-f show	jo	MD PRINCE GEORGE	HZ	YATTSVII				1 X Yes 2 No
ith the Maryland 23a or 28a-f sho	Director	10e. Street and Number			10f. Zip Code		10g. Citizen of What Cou	intry?
vith the s 23a o		6903 QUINCY STREET  11. Marital Status 12. Was Dece	edent Ever in U.S	13 W/as	20785	nic Origin? ( Specify Yes or N	U.S.A.	rican Indian, Black,
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral	1 X Never Married 2 Married Armed Fo 1 Yes 3 Widowed 4 Divorced If Yes, Give Year	rces?	If Yes		exican, Puerto Rican, etc.)	White, etc	LACK
urs aft tural" amine	d by	15. Decedent's Education (Specify only highest grad-		16a Decedent's	Usual Occupation	(Give kind of work done	Specify.  16b Kind of Businessi	Industry
	Completed	Elementary/Secondary (0-12) College (1-	4 or 5+)		t of working life. DC	NOT use retired)		
withir spene	omp	12th  17 Father's Name (First, Middle, Last)		DISAE		Mother's Name (First, Middle	PVT	
Baltimore, MD 21215-0036 permit Pages I and a should be filed within 72 Department of Health and Mental Hygiene Important: If item 27 is marked other than 'injury or other transmatic event, the Medical	Be C	JAMES JONES				OSEPHINE WILL		
21; rould b d Men s mar	ToE	19a. Informant's Name/Relationship (Type, Print )			Address (Street ar	nd Number or Rural Route No	umber, City or Town, State	
MD nd 2 sh alth an m 27 i		JOSEPHINE WILLIAMS/MOTHER				REET HYATTSVI		
Baltimore, permit Pages I an Department of Hea important: If iter		20a Method of Disposition 1 X Burial 2 Cremation 3 Removal fro	m State cr	rematory or other		11-02-200	20c. Location - City or LANDOVER,	
timent report of the contraction		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenset	HARM		ORIAL CEN	TE.		
Ba perm Depa Impo injirr		K.D. H-hali		747	4 LANDOVE	Facility JB JENKIN ER RD LANDOVE	R, MD 20785	ME
Physician /Medical		23a Part I. Enter the disease, or complications that ca failure. List only one cause on each line.	rrest, shock, or heart	Approximate Interval Between Onset and				
Examiner			nsive card		ar disease			Death
		Sequentially list conditions, b						
	ine	cause Enter Underlying Cause	consequence of)	r				
ed nsit	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a death)	consequence of)					
760, cate be executed physician and the burial - transit		▼ UNPENDED			044 44 45 4			
760, ficate be g physici the buri	/Medical	IF FEMALE. 23c. If yes, o	23a,P11,27 utcome of pregna	/ <b>, perME.s</b> ancy	<u>861,11/17/</u>		23d Date of deliver	<u> </u>
		23b Was decedent pregnant in the past 12 months?	rth int at time of deal	46		Ectopic pregnancy	Month I	Day Year
Box 68 c death certif the attending	Physiciar	1 Yes 2 No 9 Unknown 9 Unknown		5 Othe	r (Specify)			
tal Records, P.O. Box 68760, cian: The law requires that the death certificate be certificate has been signed by the attending physici ector, page 2 should be detached for use as the bunited to the contract of the contract	by P	Part II. Other significant conditions contributing to					tobacco use contribute to	
duires quires en sigr		Morbid obesity, sleep apnea	<u>, mental r</u>	retardatio	on, down's	1Y	es 2 No 3 Prot	
COFC law re has be	Completed	syndrome				auto		topsy findings available completion of cause of
		25. Was case referred to medical			20 Pl 1	1 ✓ Yes		es 2 No
Vital hysician this cert	o Be	examiner?	patient 2 E	ER/Outpatient	Oth	Death (Check only one) er	Residence 6 V Other	" Scene
ting Phy.	$\vdash$	27. Manner of Death 28a. Date of	f Injury Day, Year)	28b. Time of Inju	ıry 28c. İnjury at		how injury occurred	
ttendi death.	atio	1 X Natural 5 Pending 2 Accident Investigation	,,,,,,		1 Yes	2 No		
Division of Vital Records, To the Hospital or Attending Physician: The law require within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should be	ertification:	determined (Specify)	of Injury - At hon	me, farm, street,	factory, office build	ing, etc. 28f. Location or Town,	(Street and Number or Ru State)	ral Route Number, City
E 8 E	O	4 Homicide (Specify)  29a. Certifier (Check only)  Certifying Physician: To the best	of my knowledge	e, death occurre	d at the time, date a	Ind place, and due to the cau	ise(s) and manner as star	ted
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of and manner sta		d/or investigatio	n, in my opinion, dea	ath occurred at the time, date	e and place, and due to th	e cause(s)
	ž	29b Signature and title of certifier			29c. License nu		29d Date signed (Mo.	
NO		I headen Mi King J	ann	2	O.C.M.E	<u>.                                    </u>	October 26, 2006	>
SC		30. Name and address of person who complete cause Theodore M. King, Jr., MD. Assistar	e of děath (Item 2 nt Medical Ex		11 Penn Street	t, Baltimore, MD 2120	1	
St	ate	31. Date filed (Month, Day Year) 32. Reg	istrar's Signature	e			_	
Regist		NUV U & ZUUD Barren	4. Open	te)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year OCTOBE HNNA 23 2006 /Medical Examiner acility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Salisbur Regional Medical Wicomica reninsula Social Security Number 6. Sex If Under 1 Year If Under **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Months 1 □ M 2 X F Days Hours -12-1528 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits r 28a-f sh Director 1 PYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or items 23a or: ral", or items 23a or Examiner must be r 185 by Funeral TUC NUC 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra ONC arvin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10 Cen. 21 Singulare of Funeral Servi 23a. Part1. Enter the disease shock, or heart failure. disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPTIC Physician SHUCK /Medical Due to (or as a consequence of): Examiner ESPIKATORY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner that the death certificate be executed burial-transit .DIFF COLITIS and Due to (or as a consequence of): physician s the burial Box 68760 Physician/Medical as for use IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) Year P.0. 1 ☐ Yes 2 ☐ No 9 ☐ Unknown the 9□Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ò page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, pag 2 - No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tes 2 No 3□ DOA 1 Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10063199 23 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 BA

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT 2 5 2006

State of Maryland / Department of Health and Mental Hygiene State Registrar WEND#25perDME1()/24/06, BWW, MoCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Edward Johnson Oct. 18, 2006 5:35 P Α. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House 6001 Muncaster Mill Rd Montgomery Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** MM 2□F Director 88 17,1918 286-40-2355 Connecticut Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show amy only or other treumalic event, it a Medical Examination or confided at once. 10d, Inside City Limits 10a. State 10b, County 10c. City, Town or Location 1 Yes 2 No Directo Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A.

14. Race - American Indian,
White, etc. 10221 Gainsborough Rd 20854 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 TXYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: <u>م</u> 3 XWidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) U.S. Forest Service Research Forester 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Axel William Johnson Anna Marie Franson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Lindsey Daughter 3605 Bardfield Court Cumming, Georgia 30041 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 10/24/2006 4 ☐ Donation 5 ☐ Other (Specify) Falls Church, Va. National Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave. N.W. Washington D.C 20016 23a. Part 1. Enter the disease, or complicate is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 3 weeks Peritonitis /Medical Due to (or as a consequence of): Examiner Duodenal Ulcer Perforation Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien end for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, T Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Year Day 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown ል Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Colon Cancer 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No Coronary Artery Disease this certificate hes autopsy performed? 1□ Yes 2½ No To the Hospital or Attending Physician: After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Nother Specify Living Hospital: 1 Inpatient Yes N Certification: To 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No of Director: A ad in by the fi investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) filled in by 4 Homicide within 24 hours efter To the Funerei Dire 23s Centifier 1 Curtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the nause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number H0058032 Actober 19,2006 Centheam. Dellamo, DO. 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia M. Williams, DO. Montgomery Hospice 6001 Muncaster Mill Rd. Rockville, MD. 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2006

OCT 2 4

			1 - For State Registrar	State of Marylan			of Health a	ind Men		ene2006	35533
	Dhuaisi		Decedent's Name (First, Middle, Last)				-		Date of Death Month	Day Year	3. Time of Death
	Physici /Medio Examir	al	Lois Thomas Justi		· · · · · · · · · · · · · · · · · · ·	4b. City, To	own, or Location of	00	ctober	24 2006 4c. County of Dea	
	Funeral	_	Williamsport Nurs 5. Social Security Number 6. Security Number 1.	ing Home 7. Age (In yrs.		If Under 1	11iamspo Year   If Under 2 Days   Hours	24 Hrs. 8. [	Date of Birth Month, Day, Y	Washing	ton County thplace (State or Foreign
	Director		210-14-4069 Usuel Residence of Decedent	81	Yrs.				arch 25	1925 Pen	nsylvania
	ryland how		10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	Ba-f e	ecto	Maryland Washin	gton	Hage	rstown					1 ☐ Yes 2 No
	Mith ti	Dir	101.17 Character To	D :		10f. Zip C			10g	. Citizen of What Co	ountry?
	deeth	nera	19114 Cherry Tre	12. Was Decedent Ever in U	.S. 13. \	Was Decede	21742 nt of Hispanic Orig y Cuban, Mexican,		Yes or No-	U.S.A. 14. Race - Ame	
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural', or items 23a or 28a-1 show appring or other traumatic event, the Medical Examinar must be notified at ODGs.	Completed by Funeral Director	1 Never Married  Married	Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give	-	fYes, specif 1 □ Yes 2	_	, Puerto Rica	in, etc.)	Black, Whi	
21215-0036	tural'	ed b	3 Widowed 4 Divorced	Year or Dates:	16a. Deced	dent's Usual	Occupation		16	b. Kind of Business	
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121	Hed wi	Con	12 17. Father's Name (First, Middle, Last)		0.	ffice	Manager	de Nome / Ci	- 46-4 44	Dental O	ffice
Maryland	d be figured by the figure of	To Be							rst, Middle, Mai	iden Sumame)	
ary	and Memory	۲	Spenser Thomas  19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin	ng Address (S			Meeker ute Number, C	ity or Town, State, .	Zip Code)
	and 2 ealth a m 27 I		William H. Justic		1911	4 Cher	ry Tree I	Drive	Hagerst	town Mary	land 21742
Baltimore,	ages 1 nt of H : If Ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	lace of Dispo emetery, cren	natory or oth	er place)	Date	4	c. Location - City or	
Ħ	nit. Pa entme ortant Injury		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service (Specify)		ithsbu:	rg Cre	matory Address of Facility				Maryland
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Records,	@ G C/I	Completed							24a. Was an autopsy performed	prior to death?	itopsy findings available completion of cause of
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on o	ding l	tlon:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 280	Injury at Work? 1 ☐ Yes 2 ☐ No		Describe how i	njury occurred	
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51	4-4		30. Name and address of person who co	154 N.	Λ	Print) ZAN	ST.	Willi	AMSP	TOISER	MD
	Sta Registr	_	31. Date filed (Month, Day, Year) OCI 2 7 20	32. Registrar's Signa						- ()	
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			1 - For State Registrar	State of Ma	ryland				lealth a Death	ind M	-	giene Reg. No./	2006	3.5	534
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	/Medic Examir		Virginia Dare Ja 4a. Facility Name (If not institution, give				4b. City,	Town, or	Location of		OCCOBCI		ounty of Deat		<u>u</u>
	Funeral		Millennium Nursing 5. Social Security Number 6. S	g Home, Sou ex 7. Age □M 257 F	ith Ri	t birthday)	If Under	r 1 Year	Vater If Under 2 Hours	Min.	8. Date of Birt (Month, Da	h /, Year)	nne Ar	un de l nplace (State untry)	
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	72 hours after deeth with the Maryland neturer, or lieme 23a or 28e-f ehow dical Examiner must be notified at	_	10a. State 10b. County		10c. City, 1	Town or Loc	ation							10d. Inside	
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36	s after, or Ite	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🛣 No If Yes, Give	0		☐ Yes		Specify:	, ruento r	noan, etc.)		Black, White	ite	
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Maryland	2 should be and Mental Is marked sumatic ev	۲	19a. Informant's Name/Relationship (1			19b. Mailing	g Address	(Street a			Route Numbe		Town, State, Z	ip Code)	
	is 1 and 2 should of Health and Men item 27 is marke other traumatic		Corinne Hackett/I	aughter	The second secon					The state of the state of	inburg				
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Ħ	permit. Pages Department of t Importent: if ite eny injury or ot		20b. Place of Disposition (Name of cemetery, crematory or other place)  1												
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	bhysician bhysician and physician and physician sthe buriar-transit	icai Examiner	23a. Part1. Enter the disease, or composition shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line	consequent	Ary nce of): le you	Chy	Hom	116.				e ase	Approxima Interval Be Onset and	etween
P.O. Box 68	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours elater death.  To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal de	ath 3 🗆	Ectopic pr Other (sp					23	d. Date of delin	very Day	Year
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ō	g Phys er this eral di	٦. ح	27. Manger of Death	1 ☐ Inpatien  28a. Date of Injury (Month, Day		b. Time of		28c. Injury Work	4 Nurs		e 5 Resid			rfy)	
ion	ending sath. or: Afte	atio	1 Natural 5 Pending 2 Accident investigation		Yeer)	Injury	м		? ′es 2 □ N	lo					
Division of Vital	To the Hospital or Attending Physicien: The i within 24 hours effer death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Certification;	3 Suicide 6 Could not be determined	28e. Ptace of Injurbuilding, etc.	y - At home (Specify)	, farm, stre	et, factory	, office		2	8f. Location (S City or Tow		Number or Rui	ral Route Nur	n <i>ber</i> ,
	Hosp 24 hou Funer etely fill	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ysician: To the best of iner: On the basis of e and manner state	ixamination	dge, death and/or inve	occurred estigation,	at the tim , in my op	e, date and inion, death	place, a	nd due to the o	ause(s) ar ate and pl	nd manner as ace, and due	stated. to the cause(	s)
	To th within To th comp	Me	29b. Signature and title of certifier	. (			290	. License			2		signed (Month,		,
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	4		30. Name and address of person who of 5851 \tag{7}	eale c	hun	dite	rint) (	RO	Naci.	C.	SUR	19 NU	MD	2075	フ
	Sta Registr		31. Date filed (Month, Day, Year)  OCT 2	32. Registra	_		do	Me !							

**ORIGINAL** 

			For State		ryland / D	epartment of F Certificate of	lealth and Me	ental Hygie	ene	
			Registrar  1. Decedent's Name (First, Middle, Las	Reg 2. Date of Death	. No. 200	3. Time of Death				
	Physiciar /Medica		Elizabeth Jar			Month / O	Day Ye /7 O	6 2240 M		
	Examin	er	4a. Facility Name (If not institution, give	1 24 . 1	100	4b. City, Town, o	r Location of Death		4c. County of D	
			5. Social Security Number 6. Se		(In yrs. last birth	aday) If Under 1 Year	I SOWY	B. Date of Birth	001	COMICO Birthplace (State or Foreign
,	Funeral Director			□M 21/4F		rs. Months Days	Hours Min.	3. Date of Birth (Month, Day, Y Fune 16,		Birthplace (State or Foreign Country) Michigan
	Maryland -I show		10a. State 10b. County		10c. City, Town		a			10d. Inside City Limits
3	the Ma	ecto	MD Dorches  10e. Street and Number	cer		Woolfo	ora 	10a	. Citizen of What	1 ☐ Yes 2 📉 No
20	th with	a	1620 Church Cre	ek Road		100.24	21677		USA	,
de	ems	ner	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spec	rfy Yes or No-	14. Race - A	merican Indian, /hite, etc.
036	Ja within 72 hours after death with the Marylar piene. I than "naturel", or Items 23e or 28a-f show the Madical Examiner must be notified at	by Funeral Director	1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	1 □ Yes 2 ▼ No If Yes, Give Year or Dates:		1 □ Yes 2 🕱 No	Specify:			white
Maryland 21215-0036	within 72 h ene. than "natu	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		Decedent's Usual Occup Give kind of work done life. DO NOT use retired	ation during most of working d)	7	b. Kind of Busine	ess/Industry
212	e filed with st Hygiene other the vant, the	E	Elementary/Secondary (0-12)	College (1-4or 5+	•)	social worker			health care	
Þ		Bec	17. Father's Name (First, Middle, Last)				18. Mother's Name	First, Middle, Ma.	iden Sumame)	
<u> a</u>	should be and Mentel marked c umatic avi	2	Thomas Joyce			Carol Chadwick				
Aan	and and and and		19a. Informant's Name/Relationship (7			Mailing Address (Street				
	s 1 end 2 of Heelth Item 27 other tre		Martha Dail 20a. Method of Disposition	sister		2 Bellevue			1D 2161 c. Location - City	
Baltimore,	5 t = 1		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify		1	Disposition (Name of crematory or other place			Salisbur	
量			21. Signature of Funeral Service Licen		Salisb	ury Cremato 22. Name and Addre		mas Fune		
å	permit. Departu Importu any Inj pnce.		1B.KRD			700 Locust				
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused t	he death. Do no	ot enter the mode of dyir	ng, such as cardiac or	respiratory arrest		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Metasta	Pi /,	1.m C.	near			Onset and Death
	/Medical		resulting in death)	Due to (or as a	consequence of		non			
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	nsit	Examiner	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of	0).				
ć	te be executed ysicien and te burial-transit	Еха	that initiated events resulting in death) Last	Due to (or as a	consequence of	f):				
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89	ng ph	Med	IF FEMALE:		2					
О. Вох	at the death certificate to by the attending physicached for use as the backet.	Physician/Medi	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	/		23d. Date of Month	delivery Day Year
, P.O.	w requires that the body is been signed by should be detact	F							acco use contribute to the cause of death?	
rds		ed by						Yes	Yes 2 No 3 Probably 4 Unknown	
ဝ	has bee	Completed						24a. Was an autopsy	24b. Were	autopsy findings available to completion of cause of
<u>ac</u>	The late has page	E O						performe	d? death	1?
/ita	icien: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?				26. Place of Death	(Check only one)	<del>-</del>	
<del>_</del>	hys I di	၉	1 ☐ Yes 20 No Hospital 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)							
Division of Vital Records,		atlon	27. Manner of Teath  28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28c. Injury at Work?  1 Yes 2 No  28d. Describe how injury occurred							
Divis		Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	Hospit 24 hour Funeri etely fill	Medical	29a. Certifying Ph (Check only one) Certifying Ph	ysician: To the best of iner: On the basis of a and manner state	examination and	death occurred at the tir for investigation, in my continuous	ne, date and place, ar pinion, death occurred	nd due to the caus d at the time, date	se(s) and manne and place, and	r as stated. due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	11	/)	29c. Licens			. Date signed (M	
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			Dand E. Caust	IMO Co	estal H	Spill fo	Box 1733	Soll	sh p	10 21802
	Sta		31. Date filed (Month, Day Year) 9	2006 32. Registrar	's Signature	Annak .			)	

			_ For	State of Ma	arylan	d / Depa	artment of	Health	and Me	ntal Hyg	giene		
			For State Registrar			Cer	tificate of	f Death	•	F	Reg. Nor	6	25527
6.	Physicia	an	Decedent's Name (First, Middle, Last)     ANTONIT	A KYI	· E				2	Date of Dea Month OCT •	Day	rear	3. Time of Death 12:15 P M
	/Medic	NAME	ANTONI  4a. Facility Name (If not institution, give s		J.C.		4b. City, Town,	or Location	of Death	UCI.	23, 20 4c. County of		12:13 P
	Examin	er	, , ,					VER SE			MONT		DV
4.5		*	HOLY CROSS HOSP  5. Social Security Number 6. Sex		e (In vrs. I	last birthday)	If Under 1 Yea			Date of Birtl			IA I lace (State or Foreign
100	Funeral		· 1	M 217F	85	Yrs.	Months Day		Min.	. Date of Birtl (Month, Day	(, Year)	Coun	try)
2.	Director		579-14-1074 Usual Residence of Decedent		85					JAN. I	6, 1921	ITA	TI
	land w t		10a. State 10b. County		10c. City	y, Town or Lo	cation					1	0d. Inside City Limits
	f she	ò	MD. MONTGOME	DV			SILVER	CDDTMC	,				1 Yes 2 □ No
	the the same	Director	10e. Street and Number	IXI			10f. Zip Code		r		10g. Citizen of Wh	at Cour	trv?
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	eath is 23 mus	era	12325 NEW HAM	12. Was Decedent		S 13 V	209		rigin? (Sneci	fy Ves or No-			an Indian.
	iter d	Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑			Vas Decedent of f Yes, specify Cu	uban, Mexica	ın, Puerto Ri	can, etc.)	Black,	White,	
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ŏ	tura atura	ed	15. Decedent's Edu	cation		16a. Deced	lent's Usual Occ	upation		I	16b. Kind of Busi		
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	othe /ent,	Be C	17. Father's Name (First, Middle, Last)					18. Moth	er's Name (i	First, Middle,	Maiden Surname		
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ary	shot and N s ma uma		19a. Informant's Name/Relationship (Ty	pe. Print)		19b. Mailir	g Address (Stre	et and Numb	er or Rural I	Route Numbe	er, City or Town, S	ate, Zip	Code)
	Health a tem 27 ls		PAULA KYLE/DAU	GHTER		9824	ST.CLO	UD CT.	, FAII	RFAX,	VA. 2203	L	
ē,	othe othe		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of natory or other p	lace)	Dat	te	20c. Location - C	ity or To	wn, State
E S	Page lent c nt: If ry or		1 ☐ Burial 2XICremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			RS CREM	i i	10-24-	-2006	RIVERDA	E.	MD.
Baltimore,	permit. Pages 1 and Department of Health Important; If Item 27 any injury or other ti		21. Signature of Funeral Service License	e /	_						REMATORI		
ä	permit Depar Impor any in		20.20. (ha)	mlusau	_M00	091   5	801 CLE	VELAND	AVE.	, RIVE	RDALE, MI	)M, P	0737
	Torte S		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cation that caused	the death	n. Do not ent	er the mode of d	ying, such as	s cardiac or	respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final			CIIDAD	ACHNOTA	חד הבט	TNC				Onset and Death
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9		Med	IF FEMALE:			-						-	
Вох	death certifi e attending d for use as	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1 ☐ Live birth			Ectopic pregnar	псу			23d. Date Mont		ry Day Year
H	0 60 1	sici	1 □ Yes 2 🔯 No	4☐Pregnant a 9☐Unknown	t time of de	eath 5	Other (specify)				WORK	1	Day feal
P.	at the de d by the a etached	Physician/Me	9 Unknown	-		dalaa ia aha co		oli one la Dord		00a Did ta			e cause of death?
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10/25/04 Records,	w requires been signe should be	Completed	UKINAKI IKACI	INFECTIO	)IN					'''	es ZLXINO 3	Prob	ably 4 □Unknown
60	e law has b	ed.	PNEUMONIA							24a. Was a	sy pri	or to cor	psy findings available apletion of cause of
		Son								perfo		ath? ]Yes	2 □ No
先を Vital	Physician: The r this certificate ral director, pag	Be (	25. Was case referred to medical examiner?						e of Death (	Check only o	ne)		
50g	physic this or al dire	Lo Lo	1 ☐ Yes 2 No	lospital: 1 📉npatie	ent 2	ER/Outpatien	I 3 DOA		ursing Home	e 5 ☐ Resid	lence 6 □Other	(Specify	()
	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury	28c. In	jury at ork?	28	d. Describe h	ow injury occurred	1	
Sio	Attending r death. ector: Afte	äţi	2 ☐ Accidentinvestigation					Yes 2	]No				
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of inj building, et	ury - At ho c. <i>(Specif</i> )	ome, farm, str y)	eet, factory, offic	e	28	f. Location (S City or Tow	Street and Number vn, State)	or Rura	l Route Number,
200	oital c												<u> </u>
34	ne Hospital or Attendl n 24 hours after death he Funeral Director; A pletely filled in by the f	Medical	29a. Certifier 1 Certifying Physical Check only one) 1 Medical Exami	ner: On the basis of	f examina	wledge, deati tion and/or in	occurred at the vestigation, in m	time, date a y opinion, de	nd place, an ath occurred	d due to the d d at the time,	cause(s) and mani date and place, ar	ner as st id due to	tated. the cause(s)
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	3		1/1/2		1 /			006334	3		OCT. 24	1, 2	000
			30. Name and address of person who co					TEM DE	CTI	TUED C	מאר אור	, 0	0010
	Ch	†a	DR. IRINA RU 31. Date filed (Month, Day, Year)	BAN, M.D.	1 01			LEN KD	., 511	VEK S	PRING, MI	10 4	0310
	Sta Registr		OCT 2 5 200	16 May 10	J 1	ture	ula						

MARK W. KUYKENDALL 06-08231

Please Type or Print in Black Indelible Ink

**UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death <u>2006 35538</u> Registrar Rea No . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day October 31, 2006 **Medical Examiner** 1354 hrs Mark Kuykendal1 Warren 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Noland Ferry Road at the Monocacy River Point Of Rocks Frederick 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year **Funeral** If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or Foreign Country Director Months Days Hours Min 1 X M 2 F 214-78-0263 48 Nov. 22 1957 Indiana Usual Residence of Decedent ABI IOc. City, Town or Location 10d. Inside City Limits or 28a-f show 1 Yes 2 X No or items 23a or 28a-f shormust be notified at once. hours after death with the Maryland Maryland. Montgomery Director Germantown 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 19609 Twinflower Circle 20876 <u>United States</u> Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black Armed Forces? Never Married 2 X Married White etc. Yes 2X No Widowed If Yes, Give Year Divorced Yes 2X No specify: Specify: White is marked other than "natural", atic event, the Medical Examiner ş 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 72 hor ment of Health and Mental Hygiene tant: If item 27 is marked other than "mat or other traumatic event, the Medical F. Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Warehouse Worker Electronics 17 Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Greenwell Arthur Kuykendall Irene Cool 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD Meredith S. Kuykendall/Wife 11302 Corinthian Court, Germantown, MD. 20876 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) permit Pages 1 Department of b 1 Burial 2 X Cremation 3 Removal from State Immortant: I Metropolitan Crematory 11/2/2006 Alexandria, Virginia Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line Between Onset and /Medical a Multiple injuries Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) requires that the death certificate be executed and Physician/Medical X UNPENDED <sup>AMENDED</sup>#23a,27,28a-f, perME, g862, 12/5/06 TT attending physician or use as the burial Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnance 23d Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a Was an 24b Were autopsy findings available autopsy prior to completion of cause of performed? death? this certificate ✔ Yes 2 1 🗸 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other<sub>4</sub> Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Pending Yes 2 v No the Fnd 10/31/2006 Fnd 1:32 pm subject jumped Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City or Town, State) Noland Ferry Road at The Monocacy River, Point of Rocks, Mo Suicide Could not be determined (Specify) roadway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started within To the one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 1, 2006 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day State 2006 Registra

			1 - For State Registrar	State of Mary		artment of I <i>rtificate of</i>			$\tau$ $\alpha \alpha \alpha$	6 35539
1	Physic	ian	1. Decedent's Name (First, Middle, La	ist)				2. Date of De	ath	3. Time of Death
	/Medi		YEE HYUN	KIM					3, 06	5:00P <sup>M</sup>
	Exami	ner	4a. Facility Name (If not institution, give	·		4b. City, Town, o			4c. County of E	
	Funeral		8591 FALLS RU 5. Social Security Number 6.5		yrs. last birthday)	ELLICO			HOWAI	
	Director			1□M 2 <b>X</b> F 85	Yrs.	Months Days		in. (Month, Da)	y, Year)	Birthplace (State or Foreign Country)
	pu k		Usual Residence of Decedent					NOV 1	, 20   5	S. KOREA
	larylan show	5	,		. City, Town or Lo					10d. Inside City Limits
	the N	rect	MD HOWAR  10e. Street and Number	ΣD	ELLICO		<u>Y</u>			1 XYes 2 No
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98	or Ite	Fu	1 Never Married 2 Married	Armed Forces?  1 Yes 2 No If Yes, Give		If Yes, specify Cub		erto Rican, etc.)	Black, W	Vhite, etc.
8	ural',	d by	3 Widowed 4 □ Divorced	Year or Dates:		1 ☐ Yes 2 🌠 No	Specify:		Specify: 7	ASTAN
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yla	should be nd Mental marked o	10	JAE BUM	KIM			UN	PUCK	KIM	
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	uted i insit	nin.	cause. Enter Underlying Cause (Disease or injury	Due to (or as a coh)	requence or):					
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w		w	IF FEMALE:							
Вох	death certif e attending d for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre- 1 Live birth 2 DF	etal death 3 [	Ectopic pregnancy			23d. Date of c	
	00	ysic	1 Yes 2 No	4□Pregnant at time o	of death 5	Other (specify)			Month	Day Year
	res that the igned by be detac		Part II. Other significant conditions of	ontributing to death but not	esulting in the un	iderlying cause give	an in Part I.	23e. Did tob	Dacco use contribute	to the cause of death?
Vital Records,	law requires that the as been signed by th 2 should be detache	ed by	constipati	0		, ,				Probably 4 Unknown
00	aw re	Completed	4					24a. Was a	n 24h Were	autopsy findings available
Ä	The lay ate has page 2	mo:						autops	y prior to ned? death?	o completion of cause of
/ita	yaician: The is certificate hadirector, page	Be (	25. Was case referred to medical examiner?				26. Place of De	1 ☐ Yes 2 eath (Check only one	2 No 1 ☐ Ye	es 2 No
	Phyaia this o	2	1 ☐ Yes 2 📉 No	The state of the s	☐ ER/Outpatient	3□ DOA Othe		Home 5 Reside		pecify)
Division of	or Attanding Physician: ifter death. Diractor: After this certific in by the funeral director,	ertification:	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year,	28b. Time of Injury	28c. Injury Work	(?	28d. Describe ho	w injury occurred	
isi	death death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be		hama farm et-		/es 2□No	001 1 1 101		
<u>S</u>	al or / after Dira d in b	erti	4 - Homicide determined	28e. Place of Injury - Al building, etc. (Spe	cify)	et, ractory, office		City or Town	reet and Number or I , State)	Rural Route Number,
	Hospital or Attanding I 44 hours after death. Funaral Diractor: After tely filled in by the funer	SalC	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	sician: To the best of my k	nowledge, death	occurred at the tim	e, date and plac	e, and due to the ca	use(s) and manner a	as stated.
		ledical	one)	iner: On the basis of exami and manner stated.	nation and/or inv	estigation, in my op	inion, death occ	turred at the time, da	ite and place, and du	ue to the cause(s)
1	To the within To the comple	Σ	29b. Signature and title of certifier	1/		29c. License	number	29	d. Date signed (Mor	nth, Day, Year)
0	12	-	m m	, 5	M.D	D &	5247	9 0	ctober,	25 2006
_	(2)		30. Name and address of person who c	ompleted cause of death (II		gers f	1.100	E//: "	8 3 Ly 1	1021043
	Stat	le'	31. Date filed (Month, Day, Year)	32. Registrar's Sig		Jers +	ivenue	, Clicott	City, IV	V 21043
	Registra	ar	OCT 2.5 2006	har b A	hack	,				77

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 23 2006 Oscar ichard 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOME orsica Under 1 Year If Under 24 Hrs. Nursing ueen Anne's Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number Days 10M 2□F 18 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 Yes 2 No Annels 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? BOX 30 US 17. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation

**Physician** /Medical

**Physician** 

/Medical

Examiner

Director

ed by Funeral

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23a or 28a-f show any injury or other traumatic event, Ite Medical Exertment the redifficed and injury or other traumatic event, Ite Medical Exertment.

Baltimore, Maryland 21215-0036

Examiner

To the Funeral Diractor: After th completely filled in by the funeral within 24 hours after death To the Funeral Diractor:

Be

Medical Certification: To

25. Was case referred to medical examiner?

29b. Signature and title of certifier

31. Date filed (Month Day)

5 Pending

investigation

6 Could not be

1 ☐ Yes 2 ☑ No

27. Manner of Death Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

Hospital:

30. Name and address of person who completed sales of death (Item 23a) (Type, Print)

2006

28a. Date of Injury (Month, Day Year)

610 32 Registrar's Signature

To tha Hospital or Attanding Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

et	(Specify only highest grade completed)	(Give kind of work done during most of work life. DO NOT use retired)	king	ia or basinosamaasii y	
Complet	Elementary/Secondary (0-12) College (1-4or 5+	Truck Driver	Sea	Food Indus	stry
C	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maiden		
To B	William Harry Kir	ig Ida/	Mary Bra	Wn	
•	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rui	ral Route Number, City or	Town, State, Zip Code)	
	Angela King		Chester, M	aryland 2	1619
	20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date Loc. Loc	cation - City or Town, State	Э
	1  Burial 2  Cremation 3  Removal from State  1  Other (Specify)		30/06 Ch	ester, Mari	yland
	21. Signalare of Funeral Service Licensee				
	Hanelle C. Henr	Henry Funeral 1	to Me, Combond	20 MD. 2/613	3
T	21. Signature of Funeral Service Licensee  C. Guru  23a. Part. Enter the disease, or complications that cause of shock, or heart failure. List only one cause on each line	the drath. Do not enter the mode of dying, such as cardiac e.	or respiratory arrest,	Approxi Interval	mate Between
	Immediate Cause (Final disease or condition	walnumme of he	link	Onset a	ind Death
	resulting in death)	a consequence of):	my .	1100	
er	Sequentially list conditions, if any, leading to immediate Due to (or as a	consequence of:			-
딢	cause. Enter Underlying Cause (Disease or injury				
Examiner	that initiated events c. resulting in death) Last Due to (or as a	a consequence of);			
	`	, ,			
3	d				
Mec	IF FEMALE:				
an/	23b. Was decedent pregnant 23c. If yes, outcome of		2	3d. Date of delivery	W
100	in the past 12 months?  1 Yes 2 No  9 Unknown			Month Day	Year
hys	9 Unknown				
by Physician/Medical	Part II. Other significant conditions contributing to death but	it not resulting in the underlying cause given in Part I.	23e. Did tobacco u	se contribute to the cause	of death?
			1 ☐ Yes 2 ☐	No 3 Probably 4	Unknown
ete			04-146	045 146	
ompleted			24a. Was an autopsy	24b. Were autopsy findir prior to completion death?	of cause of
Con			performed? 1 ☐ Yes 2 ☐ No	1 Yes 2 No	

26. Place of Death (Check only one)

4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Registrar DHMH 17 Rev 1/2001

State

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

			- 10030	State of Marylan		artment of h		•		•	
			1 - For State Registrar		•	rtificate of			Reg. No.	2006	35541
П			Decedent's Name (First, Middle, Las	it)				2. Date of Dea			3. Time of Death
	Physici /Medic		Una Darlene Kor	ns				0C+	23	ZOOL	7:20 M
•	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Dea	ith	4c. C	ounty of Death	
7			Washington County 5. Social Security Number 6. Se	Hospital	in as birthdays	Hagerst	OWD Under 24 Hr	S Q Data of Bird	Was	shington	/O+
	Funeral Director			9x 7. Age (In yrs. □ M 2⊠F 61	Yrs.	Months Days	Hours Min	i. (Month, Day		Mary	
			Usual Residence of Decedent					Aug.12,	1945	indi y i	diid
	iryian show	_	10a. State 10b. County		y, Town or Lo	ocation				10	d. Inside City Limits
	8s-f	Directo	Maryland Washingt	on Hage	rstowr			1			1 ☐ Yes 2 XNo
	with to	Dir	10e. Street and Number	I.		10f. Zip Code				en of What Count	ry?
	death with the Maryland ms 23a or 28s-f show	Funeral	15818 National Pi	12. Was Decedent Ever in U	S. 13.	21740 Was Decedent of F	Hispanic Origin? (	Specify Yes or No- rto Rican, etc.)	USA 14	4. Race - America	an Indian,
	or iter		1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ☒ No	j	lf Yes, specify Cub 1 □ Ye <i>s</i> 2 ☑ No		rto Rican, etc.)		Black, White, e	tc.
D-00-C	within 72 hours after ene. than "natural", or ite he Medical Expirition	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:						Specify: Whi	te
2	"natu	Completed	15. Decedent's Ed (Specify only highest gra		16a. Deced	dent's Usual Occup kind of work done DO NOT use retire	during most of we	orking	16b. Kind	d of Business/Ind	ustry
Z	withir ene. than	dmc	Elementary/Secondary (0-12)	College (1-4or 5+)		omer Serv		i	Cred	lit Card	Processing
9	Hygi other	0	17. Father's Name (First, Middle, Last)	U			, <u>'</u>	ıme (First, Middle,			11000001119
a	uld be Aental rked c	To B	Walter Harry Minn	ich			Lillie	Ernest M	ills		
ary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural; or items 23a or 28s-f show any injury or other traumatic avant, the Medical Examiner mast be multified at once.		19a. Informant's Name/Relationship (7	Type, Print)	19b. Mailir	ng Address (Street	and Number or F	Rural Route Numbe	r, City or	Town, State, Zip	Code)
E û	and and ealth m 27			sband)	15818	Nationa	I Pike H	lagerstow	n, Ma	ryland	21740
	ges 1 if of H if ite or otl		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐		lace of Dispo emetery, crer	sition (Name of matory or other pla	1	Date		ation - City or Tov	
baitim	permit. Pages Department of I Important: If its any injury or o		4 Donation 5 Other (Specify	11 /		n Cemeter		. 27,2006	Hage	erstown,	Maryland
מ	permi Depa Impo eny ip		21. Signature of Funeral Section Lices		0s	2. Name and Addre Sporne Fu	neral Ho	me P.A.	425 S	. Conocc	ocheague St
			23a. Part Cinier the disease, or comp shock, or heart failure. List only	olications that caused the deat	h. Do not ent	er the mode of dyi	rt, Mary ng, such as cardia	land 2179	95 rest,	1	Approximate
١,	Physician		Immediate Cause (Final	one cause on each line.	1.14	Liala	Mu	//_			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a conseq	uence of):	ifte	114	enany	19	1	+ year
	Examiner		Conventially list conditions	b	·	V					J
	יי ס	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):						
	be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseq	uanaa af\:						
, 60,	be ey	calE			doned ory.						
	sician: The law requires thet the death certificate be executed certificate hes been signed by the attending physicien and rector, page 2 should be detached for use as the burial-transit		**	d							
×	death certifica e attending ph d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		7 <b>c</b>			23	d. Date of deliver	у
	death	sicia	in the past 12 months?	1□Live birth 2 □ Feta 4□Pregnant at time of d 9□ Unknown		∃Ectopic pregnanc ∃ Other <i>(specify)</i> _	у			Month	Day Year
7. D	et the	Phys	9 Unknown								
v)	The law requires thet ate hes been signed b page 2 should be deta	þ	Part II. Other significant conditions co	ontributing to death but not res	ulting in the u	ndertying cause giv	en in Part I.		1	<b>V</b>	e cause of death?
Hecord	requi	Completed						1 🗆 Y		NO 3 Proba	bly 4 □Unknown
ec	hes to 3e 2 s	mpi						24a. Was a autop perfor	sy	24b. Were autop prior to com death?	sy findings available pletion of cause of
	n: Th ficate or, pag		25. Was case referred to medical					1 ☐ Yes	20 No	1 ☐ Yes	2 No
5	Physician: this certific ral director,	To Be	examiner?	Hospital: 1 Inpatient 2 □	ER/Outpatier	nt 3 DOA Ott	200	eath (Check only or Home 5 - Resid		Other (Specific	
ō	aing Phys n. After this funeral di		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of			28d. Describe h			
VISION	ath. or: Aft	atio	1 ⊠Natural 5 □ Pending 2 □ Accident Investigation		Injury		Yes 2 □ No				
	r Attu ter de irecto	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (S City or Tow		Number or Rural	Route Number,
ב	oital o		20-0-0								
	To the Hospital or Attanding Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate h completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one)  1 Cartifying Ph. 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, deatl tion and/or in	h occurred at the ti vestigation, in my o	me, date and plac opinion, death occ	e, and due to the c curred at the time, o	cause(s) a date and p	nd manner as sta place, and due to	ited. the cause(s)
	of the	Me	29b. Signature and title of certifier	and mariner stated.		29c. Licens	se number		29d. Date	signed (Month, E	Pay, Year)
	->-0		>H. Illa	al.	_ M	00	1-1-1.M	3	10	121,10	/
			30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print)	MOH	. (	10	INHIC	
2/	1-7		Hind Ha	molan, mi	11.	30 01	JAL C.	T. He	19e	rate wn.	m 21740
	Sta		31. Date filed (Month, Day, Year) 2(	32. Pegistrar's Signa		reles		11.	Q		
2	Registr	ar -		PLACE MAN 1	1 15 PM	The State of the S					

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Reg. No 2 U U 6 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) OCTOBER 22, 2006 **Physician** EDWARD HAROLD KING, SR. 9:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13050 GUY WASHINGTON ROAD NEWBURG CHARLES 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 ₹ M 2 □ F Months Hours Yrs 70 Director 217-30-0845 NOV. 5,1935 MARYLAND Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director MD CHARLES NEWBURG 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code or iteme 23a 13050 GUY WASHINGTON ROAD 20664 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. ğ 3 Widowed 4 Divorced BLACK 'natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7, hand Mental Hygiene. 7 is marked other than "no Elementary/Secondary (0-12) College (1-4or 5+) 10 LABORER CONSTRUCTION 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be RAYMOND KING BLANCHE IOLA BLAND KING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m eny injury or other traum once. DOROTHY KING/WIFE 12989 MT. VICTORIA ROAD, MT. VICTORIA, MD 20661 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/27/2006 TRINITY MEMORIAL GARDENS WALDORF, MD 21. Signature of Funerari Service Litensee THORNTON FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20640 Immediate Cause (Final ROSTATE **Physician** METASTATE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit and Due to (or as a consequence of): ed by the attending physician detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Acidence 6 Other (Specify) 201No 2 ER/Outpatient 1 Yes 1 Inpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manney of Death Certification: 28d. Describe how injury occurred After 1 the Hospital or Attending hin 24 hours after death. 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 29a. Certifier 1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO05 9942 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8926 Woodyard Rd. Clinton. Md 20735 Uncology Hemetology associates 32. R distrar's Signature 31. Date filed (Month State 2006 4 Registrar

		•	1- State of Maryland / Department of Certificate of	Health and r f <i>Death</i>		ene2006	35543
	Dhysiair		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic	al .	Audrey A. Kempton 4a. Facility Name (If not institution, give street and number) 4b. City, Town,		October	18, 2006	
)	Examin	er		or Location of Death	1	4c. County of Deat	
	Funeral		1215 Hilltop Drive Annapo  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	r If Under 24 Hrs.	8. Date of Birth	Anne Aru	
	Director		220-07-7345 1 M 2 X X 88 Yrs. Months Days	s Hours Min.	8. Date of Birth (Month, Day, Apr. 21	, 1918 Ma	hplace (State or Foreign untry) ryland
	pu *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Maryiz f sho	5	Maryland Anne Arundel Annapolis				1 ☐ Yes 2 No
	r 28a	rec	10e. Street and Number 10f. Zip Code		10	g. Citizen of What Co	untry?
	death with the Maryland ms 23a of 28a-f show rriust be notified at	Funeral Director	1215 Hilltop Drive 2140	)9	J	Jnited Sta	tes
	r dea	ner	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Marned 1 Yes 2 No	Hispanic Origin? (Siban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	
30	be filed within 72 hours after death with the Marylan de Hyglene.  de Hyglene.  de Other than "naturel", or Items 23a or 28a-f show event, the Madical Examinar must be notified at	by Fi	1 □ Never Married 2 □ Married 1 □ Yes 2 ሺ ∭No 1 □ Yes 2 ሺ No 1 □ Yes 2 ሺ No 1 □ Yes 2 ሺ No	o Specify:		Specify:	White
ž	2 hou	ted	15. Decedent's Education 16a. Decedent's Usual Occi (Specify only highest grade completed) (Give kind of work don	upation	1	6b. Kind of Business/	Industry
9500-61212	ithin 7 ne.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retire	red)	Kiirig	C	
7	iled w Hygier ther th		12 Secretar  17. Father's Name (First, Middle, Last)	<del>-</del>	ne (First, Middle, M	State Gov	ernment
	d be fi	o Be	William Henry Arnold		rundel Jo		
Maryland	2 should be filed v n and Mental Hygie is marked other t raumatic event, th	ဥ	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Stree				
Ž	and 2 salth a n 27 ls		Martha Conner / Daughter 1215 Hillton				
Baitimore,	Jes 1 t of He If Item or oth		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other pl	ace)		Oc. Location - City or	
	t. Partmen	i	4 Donation 5 Other (Specify)  Crownsville Vet.				al Home,Inc
ğ	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked eny injury or other traumatic ev DRCB.						s, MD 21401
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line.	ing, such as cardiac	or respiratory arres	st,	Approximate Interval Between
3	Physician		Immediate Cause (Final disease or condition a. Lung Cancer caution a.				Onset and Death 4 Inuniths
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				
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	cuted hd ransit	Examiner	that initiated events				
Ď,	oe exe cien a purial-1	I Ex	resulting in death) Last Due to (or as a consequence of):				
98/60	ificate be executed g physicien and as the burial-transit	edicai	d				
XOR		N/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of del	ivery
_•	0 0	Physician/M	in the past 12 months?  1 ☐ Yes 2 ☑ No  1 ☐ Like birth 2 ☐ Fetal death 3 ☐ Ectopic pregnant at time of death 5 ☐ Other (specify).			Month	Day Year
r Ö	that the de led by the a detached f	Phys	9 Unknown		230 Did tobe	acco use contribute to	the square of death?
ďż,	8 69	d b	Part II. Other significant conditions contributing to death but not resulting in the underlying cause g	jiven in Part I.		2 □ No 3 ₽Pr	
Records,	- Q =	ete			24a. Was an		
Š	The law ate has b page 2 sl	Completed			autopsy perform 1 Yes 2	ed2 prior to death?	topsy findings available completion of cause of
Vital	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?	26. Place of Dea	th (Check only one		2010
o   	hys this al di	၉	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	ther: 4 \sum Nursing H		ice 6 Other (Spe	cify)
	ling After	ion	27. Manner of Death 1 12 Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation 28a. Date of Injury 28b. Time of Injury W	uryat ork? ∐Yes 2∐No	28d. Describe how	v injury occurred	
Division	or Attending after death. I Director: After d in by the fune	fica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office			et and Number or Ru	ural Route Number.
S		Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town,	State)	
	To the Hospital of within 24 hours af To the Funerel D completely filled in	ledicai (	29a. Certifier (Check only one)  1 Cartifying Physician: To the best of my knowledge, death occurred at the (Check only one)  2 Madical Examiner: On the basis of examination and/or investigation, in my and manner stated	time, date and place opinion, death occu	, and due to the cau	use(s) and manner as te and place, and due	stated. to the cause(s)
	o the ithin 2 o the omplei	Med	29b Signature and title of certifier 29c. Licer	nse number	29	d. Date signed (Monto	h, Day, Year)
}	⊢ s ⊢ ŏ	11	> Buralle & Mills MD D:	50152	0	ctoper 1	9,2006
	h		30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)	15.10.1	ιΛ		2////
	7		Bingitta E Miller MD 2003 Med  31. Date filed (Month, Day, Year) 32. Affistrar's Signature	ical farke	vag rtvli	repoli- M	0 21701
	Sta Registr		31. Date filed (Month, Day, Year) 32. Phistrar's Signature				

			1 - For State Registrar	State of Marylar	•		nt of H		nd Me		jiene	2008	35	544
			1. Decedent's Name (First, Middle, Las	")		_			2	2. Date of Dea Month	th Day	Year	3. Time o	of Death
	Physicia /Medic		Cynt	thia I	7		Lee		(	October		2006	6:50	A M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City	, Town, or	Location of	Death		4c.	County of Dea	ath	
			Frederick Memoria	al Hospital			ederi					Freder		
	Funeral Director		5. Social Security Number 6. Se  2/5-26-8707  Usual Residence of Decedent	7. Age (In yrs.	/ast birthday) Yrs.	If Unde Months	Days	ff Under 2 Hours	4 Hrs. 8	Date of Birth (Month, Day (C7 3	; Year)	9. Bi	rthplace (State country)	or Foreign
	Maryland -f ehow lied at	tor	10a. State 10b. County  The Degree 10a. State 10b. County		ty, Town or Lo		ccl						10d. Inside C	ity Limits
	with the a or 28e the noti	Funeral Director	10e. Street and Number 98 McMuRK			10f. Z	p Code			1	0g. Citi	zen of What C		
	ne 23	era	11. Marital Status	12. Was Decedent Ever in U	J.S.   13. 1				in? (Spec	fy Yes or No-		14. Race - Am	r	
21215-0036	d within 72 hours after death with the Maryland Jiene r than "naturel", or iteme 23a or 28e-f ehow The Medical Examinar must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:			2□₩o		Puèrto Ri	fy Yes or No- ican, etc.)		Black, Wh Specify: A	LACIL	
Ö	2 ho	Completed	15. Decedent's Ed		16a. Dece	dent's Us	ual Occupa	ition	-6		16b. Ki	nd of Business	s/Industry	
7	within 7 ene. than "n	ple	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)			-M179	lu <i>ring m</i> ost )	or working				<i>c</i> .	-
7	led wit lygiane her the	EO.		IUR.	100	och.	SERV	ICE		/	NEL	). CM TY	School	25
	# H # 6	Be	17. Father's Name (First, Middle, Last)							First, Middle,	_			
<u>a</u>		To	DONALD B	Ay TONE				Am	ANC	dA 1	PE	4~/		
, Maryland	ges 1 and 2 should t of Health and Mer If Item 27 is marks or other treumatic		19a. Informant's Name/Relationship (7	(Aughter)	19b. Mailir 9 D	-				Route Number			Zip Code) 21701	/
Baltimore,	of Hea		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		Place of Dispo cemetery, crea	sition (Na matory or	ime of other place	∍)	✓ Da	te	20c. Lo	cation - City o	r Town, Slate	
Ĕ	permit. Pages to Department of Himportent: If Ite eny Injury or ot once.		4 □ Donation 5 □ Other (Specify	) FA	1RVIEW	J Ci	META	ne O	cT. 2	7,2000	F	nes i	ケン・	
aĦ	mit. porte y Inju		21. Signature of Funeral Service Acens	600	22	2. Name a	nd Addres	s of Facility	GAR	UL. R	ell ।	MSFu	neam 1	YORE
0	Dep of the control of		Done Thor	el-		110	W.	Sac	rh	ST. F	VEA	.mo.	2170	/
	Physician /Medical		23a. Part 1. Enter the disease, or comp shock, or heard failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. BREAST C Due to (or as a conse	ANCE	er the mo	de of dying	g, such as c	cardiac or	respiratory arr	est,		Approxima Interval Be Onset and	tween
,160,	te be executed was in being and inspecial transit in burial-transit in the burial-transi	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	,									
687	# × 6			d										
.O. Box 6	The law requires that the death certificat sie hes been signed by the ettending phy page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	⊒Ectopic   ⊒ Other (s	oregnancy specify)					23d. Dale of de Month		Year
۵.	ires that t signed by	by	Part II. Other significant conditions co	ontributing to death but not re	sulting in the u	nderlying	cause give	en in Part I.			bacco u		to the cause of	
Vital Records,	e law requir hes been si je 2 should	Completed								24a. Was a	an Sv	24b. Were a	utopsy findings completion of	
		ပ်								1 ☐ Yes	med? 2 ☑ No	death? 1 ☐ Ye		
/ita	ician: ] certifice rector, p	Be	25. Was case referred to medical examiner?	IIikef.			100		of Death (	Check only or	10)			
of	Phys rthis reldii	on: To	27. Manner of Death  1. Natural 5 Pending	Hospitaf: 12 Inpatient 2 [ 28a. Date of fnjury (Month, Day Year)	28b. Time o	f	28c. Injury Work	at	28	e 5 Residente de R			ecify)	
Division	r Attending ter death. Irector: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of fnjury - At l building, etc. (Spec	nome, farm, str	M reet, facto		Yes 2 □ N		If. Location (S City or Tow	treet an n, State	d Number or F )	Rural Route Nur	mber,
	itai c irs af ral D led ir		•											
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one)  2 Medical Exam	ysician: To the best of my kr iner: On the basis of examin and manner stated.	owledge, deat ation and/or in	vestigatio	n, in my op	pinion, deatl	l place, an h occurred	d at the time, d	late and	place, and du	e to the cause(	s)
	To T To I	Σ	29b. Signature and title of certifier				9c. License	-11	10			-	nth, Day, Year)	
			160	M.D.			)00(	504	19	(	007	OBER	24,200	06
	15		30. Name and address of person who											
	1.7		HENRY GASA	Y, FREDERIC	K MEI	MORI	AL HI	OSPITE	<del>}</del> L					
	Sta Regist		31. Date filed (Month, Day, Year)  OCT 2 7	Y FREDERIC 2006 32. Algistrar's Sign	aturg 1	bod								

			1 - For State Registra AVEND#7 per FH10/	State of /25/06,BMW			artment o				gienez () (	16	35545
			1. Decedent's Name (First, Middle, Las							2. Date of Dea		Year	3. Time of Death
	Physici /Medio		TERESA ES	STELLE	LA	NCASI	ER			oct.	17 <sup>Day</sup> 200	6	7:00PM
	Examir		4a. Facility Name (If not institution, give	street and numb	ver)		1	n, or Location			4c. County of	of Death	
			Casey House					ckvill			Mont	~	
	Funeral Director		377-80-9042		Age (In yrs. 9 - 59 -	last birthday) Yrs.	If Under 1 Y Months Da	ear If Unde ays Hours	Min.	North De	1946	9. Birthpl Coun Ma	ace (State or Foreign try) ryland
	and *		Usual Residence of Decedent  10a, State 10b, County		10c. Cit	ty, Town or Lo	ocation					10	Od. Inside City Limits
	Aaryl eho	ŏ	MD Montgo	moru.		C d 1	ver S	orina					1⊠Yes 2□No
	28a	Tec.	10e. Street and Number	лпету		טדד	10f. Zip Co				10g. Citizen of W	hat Coun	try?
	death with the Maryland rms 23a or 28a-f ehow	<u>=</u>	12805 Tourmali	ine Cou	rt		2	0904			U.S.	Α.	
	death	Funeral Director	11. Marital Status	12. Was Decede Armed Force	ent Ever in U	.S. 13.	Was Decedent	of Hispanic O	rigin? (Sp	ecify Yes or No- Rican, etc.)	14. Race		an Indian,
Q	after or its	E.	1 Never Married 2 Married	1 Yes 2	N No	1	1 □ Yes 2 <b>%</b>			nican, ecc.)		t, White, $_{ m s}$	
2	rel',	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Date	es:				·				
ភ្ជ	natu	Completed	15. Decedent's Ed (Specify only highest gra-			16a. Deced (Give	dent's Usual Oi kind of work di DO NOT use re	ccupation one during mo	st of work	ing	16b. Kind of Bus	siness/inc	ustry
7	than the	ם	Elementary/Secondary (0-12)	College (1-4	or 5+)		omest:				Home		
2	12 should be filed within 72 hours after and Mental Hygiene. 7 is marked other than "naturel; or ite iraumatic event, the Medical Examinations."	ပို	11th 17. Father's Name (First, Middle, Last)			1			her's Nam	e (First, Middle,	Maiden Sumame		
2	d be ental	To Be	Costello	Nelso	n					Young		,	
	Shoul od Ma mari	F	19a. Informant's Name/Relationship (7	Type, Print)		19b. Mailir	ng Address (St				r, City or Town, S	state, Zip	Code)
Ξ	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23s or 28s-1 show other traumatic event, the Madical Examican count be notified at		Lovella Blanto	n- Sis	ter								MD20904
1)	f Health f Health ltem 27 other tr		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of	of	ic c	Date	20c. Location - C	City or To	wn, State
allimo	permit. Pages i Department of t Importent: if ite any injury or ot once.		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		are i		Heave		10/2	28/06	Silver	Sp:	ring, MD
	mit. partm porte r Inju		21. Signature of Funeral Service Licen	589							Funera	1 11	ome, PA
Ď	Departiment Important Info	-	Lexello 4	Xena	well	ul	246 N.	. Wash	ingt	ton St	Rockvi	11e	,MD20850
	Physician /Medical Examiner		23a. Part 1. Enter the dise se, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a END		MULT	er the mode of			or respiratory ar	rest,		Approximate Interval Between Onset and Death
,00,	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a conseq								
00	ntifica ng ph	0	IF FEMALE:										
	w requires that the death certific been signed by the attending p should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 ⊡Feta ntattime of d	al death 3	Ectopic pregn Other (specif	ancy y)			23d. Date Mont		ry Day Year
ŗ	s that ned t	by Pi	Part II, Other significant conditions or	ontributing to deal	th but not res	sulting in the u	nderlying cause	a given in Part	: I.	23e. Did to	bacco use contril	bute to th	e cause of death?
2000	quire nn slg uld b									1 🗆 Y	es 2 No	3 🗌 Proba	ably 4 Unknown
2	lawre	Completed								24a. Was	an 24b. W	ere autop	sy findings available appletion of cause of
ב	The la te ha age 2	E					· · · · · · · · · · · · · · · · · · ·			autop perfor 1 Yes	med? de	ath?	ipletion of cause of 2 🔯 No
		a a	25. Was case referred to medical					26. Plac	ce of Deat	Check only or		165	2 22 140
_	Physici this cer al direc	To B	examiner? 1 ☐ Yes 2 ☐ XSo	Hospital: 1   Inp	atient 2	ER/Outpatien	nt 3 DOA	O#		-	-	r (Specify	Hospice
NISIOI O	nding Ph ath. r: After th		27. Manner of Death 1. Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury		Injury at Work? 1   Yes 2		28d. Describe h	ow injury occurre	d	
22	tal or Atters after de al Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	286. Place of	Injury - At h	ome, farm, str fy)	eet, factory, of	fice		28f. Location (S City or Tow	treet and Number n, State)	r or Rurai	Route Number,
	To the Heepital or Attending Physicien: within 24 hours after death  volume the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier 1★ Certifying Ph (Check only one) 2 Medical Exam	ysician: To the basiner: On the basiner and manne	is of examina	owledge, death ation and/or in	n occurred at the vestigation, in i	ne time, date a my opinion, de	and place, eath occur	and due to the d red at the time, d	ause(s) and man date and place, ar	ner as stand due to	ated. the cause(s)
	HIM Z	Σ	29b. Signature and title of certifier	Dilles	ms I	00		cense number 0058			Pate signed Love		
			30. Name and address of person who compatible M. Wi					ster	Mil]	. Rd Ro			1D 20853
	Sta	ite	31. Date filed (Month, Day, Year)	32. Reg	istrar's Signa	ature //	AP 0						

Registrar



			1 - For State Registrar		State of	Marylar	nd / Depa		t of H	ealth a		ental Hy	giene Reg. No 20	06	35546
	Physici	an	1. Decedent's Nam									2. Date of Dea	ath Day	Year	3. Time of Death
Y	/Medic	al			n Leach,			41 - 51	_			Octob	er 21,		2:00 a M
1	Examir	er			give street and num	ber)				Location of			4c. Count	of Oeath	
	Funeral		5. Social Security N	abiona D Number 6		7. Age (In yrs.	last birthday)	If Under	1 Year	orine If Under	24 Hrs.	8. Date of Birt	h		iomery place (State or Foreign ptry)
	Director		217-44-	6376	1 <b>⊊</b> M 2□F	- 63	Yrs.	Months	Days	Hours	Min.	(Month, Da)		1000	land
	and **		Usual Residence o	Decedent 10b. County		10c. Ci	ty, Town or Lo	cation							0d. Inside City Limits
	Maryll	ō	Maryland	_	ntgomery		Silve		ina						1 ☐ Yes 2 ☐ No
	r 28a	rec	10e. Street and Nu	L	11090027		21110	10f. Zip					10g. Citizen of	What Cour	
	15 with with 23 a o	by Funeral Director	13916	Tabiona	Drive			20	906				USA		
	r dea	ner	11. Marital Status		12. Was Deced	dent Ever in U	l.S. 13.	Was Deced	tent of His	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	14. Rac	e - Americ	
36	s afte	y F.	1 Never Marr	ied 2 Married	If Yes, Give	•		1□Yes				, , , , , , , , , , , , , , , , , , , ,	1	<sub>y:</sub> Whi	
21215-0036	72 hours aller death with the Maryland natural; or items 23s or 28s-f show dical Examiner must be notified at	edt	3 🗆 Midowad	15. Decedent's	Year or Da	tes: 196	9-75 16a. Dece	dent's Usua	d Occupa	tion			16b. Kind of B	usinges/lo	duetny
215	hin 72	plet	(Spec	ify only highest	grade completed) College (1-	4or 5+\	(Give	kind of wor DO NOT us	rk done d	urina most	t of workir	ng	TOO. TAING OF E	u311103341110	Justiy
7	ed wit	Completed			5+		Hosp	ital	Admi	nist	rator	:	Vetera	n's H	ospital
n D	d oth	Be	17. Father's Name			•							Maiden Sumar	ne)	
<u>\sqr</u>	J Men J Men	မ			n Leach,	Sr.			10.00			Saither			
Maryland	d 2 st th and t7 ts n traun		19a. Informant's Naryl B.										r, City or Town, pring,		
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deprintment of Health and Mental Hygiene.  Deprintment of Health and Mental Hygiene.  Be strong the maryla marked other than "natural", or itema 23a or 28a-1 ahow any njury or other traumatic avent, the Maritral Examiner must be notified at once.		20a. Method of Dis	position		20b. I	Place of Dispo	sition (Nan	ne of			ate	20c. Location		
Ê.	Page: lent of nt: if i			Cremation 3 5 ☐ Other (Spe	Removal from S	tater	ropolita	-			otob 200	er 27		-	Virginia
Baltimore,	mit.	1	21. Signature of Fu						_			-	Home I		viiginia
<b></b>	8858		10	mes 5	Ocole	-									MD 20901
) F	Physician /Medical		23a. Part1. Enlar t shock, or hea Immediate Cause disease or condition resulting in death)	rt fallure. List on (Final	ompfications that cally one cause on ea	ch line.	y ar	er the mode Lery				respiratory ari	rest,		Approximate Interval Between Onset and Death
	Into law requires that the death certilicate be executed to the last been signed by the attending physicien and page 2 should be detached for use as the burial-transit of	dical Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death) I	imediate orlying injury	b Due to (o	r as a consec r as a consec r as a consec	uence oi).								
.O. Box 6	that the death certific ed by the attending pi detached for use as t	Physician/Med	IF FEMALE: 23b. Was deceden in the past 12 1  Yes 2[ 9  Unknown	months?		th 2 ∏ Feta ntattime of d	Ideath 3□	Ectopic pre					23d. Da Mo	te of delive	ry Day Year
Records, P	w requires that been signed t should be dete	۵	Part II. Other signif	icant conditions	contributing to dea	ith but not res	ufting in the ur	nderlying ca	tuse giver	n in Part I.			bacco u <i>s</i> e cont		e cause of death?
ပ္က	aw re	Completed										24a. Was a		Were autop	osy findings available
ř	the lay	E										autops perfor	med?	orior to con death? □ Yes	npletion of cause of
/Ita	nysician: The la	Be	25. Was case refer examiner?	red to medical						26. Place	of Death	Check only or			
5	ruysician: rthis certifica ral director.	ဍ	1 ☐ Yes 2 💽		Hospitaf: 1 ☐ Inj		ER/Outpatien			4 🗀 1901	sing Hom	e 5 🗆 Resid	ence 6 🗆 Oth	er (Specify	)
ב	After After funera	Ö	<ol> <li>Manner of Death</li> <li>Matural</li> </ol>	5 Pending	28a. Date of (Month)	Injury Day Year)	28b. Time of Injury		Bc. Injury Work	?		3d. Describe h	ow infury occur	ed	
Division of Vital	after death	licat	2 ☐ Accident 3 ☐ Suicide	investigat 6 ☐ Could not	be 29a Blace o	f foiuny - At h	ome, farm, stre	M factory		es 2□N		Of Location (S)	treat and Numb	ar or Our	Route Number,
2	after Dire d in b	Certification:	4 🗌 Homicide	determine	building	, etc. (Specif	y)	et, lactory,	Office		2	City or Town	n, State)	er or Hurai	Houle Number,
	lo the hospital of Atlanding within 24 hours after death.  To the Funeral Director: Atlant completely filled in by the funeral or the funeral	Medical	29a. Certifier (Check only one)	1 Certifying I 2 Medical Ex	Physician: To the bas aminer: On the bas and manne	is of examina	wledge, death tion and/or inv	occurred a estigation,	it the time in my opi	e, date and nion, death	place, ar	nd due to the c	ause(s) and ma ate and place,	nner as sta and due to	ated. the cause(s)
	within 2 To the complet	ž	29b. Signature and	title of certiffer	//			29c.	License	number	- 0	2	9d. Date signer	Month, D	Day, Year)
1	4+1		(or	5/	1-11	4.13.			000	5 +0	03	_	Octobe	~25	,2006
4	. ( -			TORY		of death (Item	1 23a) (Type, I	2 2 2 5	5h	ady	Gre	veRe	(#201,	Rock	, 2006 Culle, UD 20850
1	Sta Registra		31. Date filed (Mont	OCT 2 6	2006 32. 8	gistrar's Signa	ture	ade							

State of Maryland / Department of Health and Mental Hygiene 35547 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Edna Mae Lehrman 12:45 M Oct. 20, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner National Lutheran Home Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF 342-22-0114 78 Director Apr. 25, 1928 Illinois Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mudical Examples invest by notified at 10d. Inside City Limits Md. Montgomery Rockville 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9701- Veirs Drive 20850 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after d
Department of Health and Mental Hygiene
Important: if item 27 is marked other than "natural", or item
any injury or other traumatic event, the Medical Engine 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Homemaker At Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frederick G. Kramer Mabel Nelson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Lehrman- Son 3914- Virgilia Street, Chevy Chase, Md. 20815 20b. Place of Disposition (Name of 20a, Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place)
Metropolitan Crematory-10/21 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Alexandria, Va. ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility W. M 2222-Wisconsin Ave, NW Hysong Co., Inc. Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List do y one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) SE PSI 5 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner and I-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): as the burial-Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) Yes 2 No 9☐ Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient 1 Yes 2 No Other: 4X Nursing Home 5 Residence 6 Other (Specify) 10 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death e Hospital or Attending Pl 24 hours after death. e Funeral Director: After the Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicaf Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) D0050612 MID October 21, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Samuel Maller 9701-Veirs Dr., Rockville, Md. Dr. 31. Date filed (Month, Day, Year, 22. Registrar's Signature OCT 25 2006 Registrar Janes

Livingston

7. Age (In yrs. last birthday)

69

Certificate of Death

Waldorf

4b. City, Town, or Location of Death

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

32.

Krishan Mathur, M.D.

5 2006

31. Date filed (Month, Day, Year) 0CT 2

P.O.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2. Date of Death Month Year 21,2006 1:30A October 4c. County of Death Waldori If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) March 12,1937 Charles Birthplace (State or Foreign Country) PA10d. Inside City Limits 1 ☐ Yes 2X No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. White Specify: 16b. Kind of Business/Industry Oil Company Charlotte Recard 20c. Location - City or Town, State Heidlersburg, PA 20646 Approximate fnterval Between Onset and Death 23d. Date of delivery Month Dav Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 X No 28d. Describe how infury occurred Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year)

October 23,2006

State Registrar For State Ragistrar

5. Social Security Number

170-30-3636

Physician

/Medical

Examiner

**Funeral** 

Director

1. Decedent's Name (First, Middle, Last)

Norman

4a. Facility Name (If not institution, give street and number)

8753 Valley Drive

Darrell

1 ₹M 2 □ F

Box 1703 La Plata, MD 20646

State of Maryland / Department of Health and Mental Hygien [ ] 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12:25 A M Verna Decenia Lewis Lester October 16, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Prince Georges If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Aug • 23 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Funeral Months 1 M 2XX 374-24-7431 Director 84 1922 Louisiana Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show ir than "natural", or items 23a or 28a-f show the Madical Examiner must be notified at Completed by Funeral Director 1 X Yes 2 ☐ No D.C. N/A Washington the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 1426 Montague Street, N.W. 20011 United States Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, polymit. Pages 1 and 2 should be filed within 72 hours after to be partment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Item any Injury or other traumatic event, the Madical Exeminations. 1 Yes 2 No If Yes, Give Year or Dates: Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: African American 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Dietary N.I.H. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Lewis Mary Davis ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnne Jones (niece) 4105 Caribon Ct., Mitchellville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial Oct. 21, 2006 4 ☐ Donation 5 ☐ Other (Specify) Landover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitMcGuire Funeral Service Thomas 7400 Georgia Ave. N.W., Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) RESISTANT /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any, leaving to limited at cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4☐ Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ XNo 9 Unknown 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 ☐ Yes X☐ No funeral director. Be 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient this 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Injury 1 X Natural 5 Pending after death.

Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral I Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-17874 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 717 - 38COTTAGE CITY, MD S.M.NAYAR 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 24 2005 Registrar

		State of Maryland / Depa State of Maryland / Depa = State	artment of Health and M			35550
		Registra MEND# 16 bper H10 / 24 / 06 , BMW , MOCO 1. Decedent's Name (First, Middle, Last)	lilicate of Death	2. Date of Death	. No.	3. Time of Death
Physicia /Medic		Edward Leonard		October	7, 2006	6:10 PM M
Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
		102 Crain Highway North  5. Social Security Number 2 (6. Sex 7. Age (In yrs. last birthday))	Glen Burnie  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Anne Ar	undel hplace (State or Foreign
Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs, last birthday) (10 M	Months Days Hours Min.	April	1,1937 W	ashington,
yland		10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits
e Mar	Director	MD Anne Arundel Glen E	Burnie			1 Tes 2 No
th with th		$^{10 ext{o} ext{e} ext{Number}}$ Crain High Way	10f. Zip Code	10g	United	,
is 1 and 2 should be filed within 72 hours after deeth with the Maryland of Health and Meahall Hygiene.  If Health and Meahall Hygiene.  Other treumatic event, the Madical Examinar must be notified.	by Funeral	1 Never Married 2 Married 1 Tel As 2 No	Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto 1  Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	
72 hc	Completed	15. Decedent's Education 16a Deced (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16	b. Kind of Business	_
within then then	ошо	Elementary/Secondary (0-12)   College (1-4of 5+)	tering Trúck Ow		Fence	Company <del>Comapny</del>
other	BeC	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		
2 should be filed with and Mental Hygiene. Is marked other the	P	Edward Jenner Leonard		e Vaugh		
C, IVICII		19a. Informant's Name/Relationship (Type, Print)  Dawn Vlahos / Daughter 119	ng Address (Street and Number or Run 035 South St. L	ibertyt	Own, MD 2	21 <b>7</b> 62
permit. Pages 1 av Department of Hea Important: If Item eny injury or othe		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ᡚ Donation 5 □ Other (Specify)  20b. Place of Dispocemetery, crem HOWard	sition (Name of natory or other place)  Medical Sch. 1		oc. Location - City or Washin	
pontari y injur		21. Signature of Funeral Service Liconsee	. Name and Address of Facility $\mathrm{AU}$			
			3821 14th Stree			
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	er the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)  RESPIRATORY  Due to (or as a consequence of):	MRKESI			
Examiner		PIGHT UPPER	LUNG MASS			
P #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
ficate be executed physicien and is the burial-transit	Examine	Cause (Disease or influry that initiated events resulting in death) Last    Due to (or as a consequence of):				
tte be a sysicier he burri	edical	d				
entifica ling ph	Med	IF FEMALE:				_
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours alter death.  To the Funarial Director: After this certificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/M		Ectopic pregnancy Other (specify)		23d. Date of del Month	ivery Day Year
thet the	by Ph	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
quires an sign				1 ☐ Yes	2 □ No 3 □ Pr	obably 4 🕅 Unknown
The law re te hes becage 2 sho	Completed			24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
sien: artifica ctor, p	BeC	25. Was case referred to medical examiner?		h (Check only one)	-1.5	
Physic this co	၉	1 Tes 2 Mo Hospital: 1 Inpatient 2 ER/Outpatien  27. Manner of Death 28a. Date of Injury 28b. Time of		ome 5 Aesiden	ce 6 Other (Spe	cify)
ding I	tlon	27. Matural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	28c. Injury at Work? M 1 □ Yes 2 ☑No	ZOU. Describe now	injury occurred	
To the Hospitel or Attending Physicien: The law within 24 bours after death. To the Funaral Director: After this certificate hes completely filled in by the funeral director, page 2	ertification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28l. Location (Stre City or Town,	et and Number or Ri State)	ural Route Number,
Hospitel 24 hours Funaral tely filled	edical C	29a. Certifier (Check only one)  1. Certifying Physicien: To the best of my knowledge, death 2. Medical Examiner: On the basis of examination and/or in and manner stated.				
o the vithin 2 o the comple	Med	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Mont	h, Day, Year)
F > F 0		mite Whandler my	20052490	0	ctobes, 1	6,2006
		30. Name and address of person who completed cause of death (Item 23a) (Type, Anita Khan (Liwa) MI) 3501	, s. Hanovast.	Baltons	u and 2	2/228
Sta Registr		31. Date filed (Month, Day, Year) OCT 2 4 2006 32Registrar's Signature	uli			

State of Maryland / Department of Health and Mental Hygien ? 116

		•	For State Registrar	State of I	Maryland / Dep <i>Ce</i>	artment of He	ealth and l		ien@ () () 6	35551
7	Dhusiai	2	1. Decedent's Name (First, Midd	le, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		KWANG	MYOUNG	LE				21, 2006	11:15a <sup>M</sup>
1	Examin	er	4a. Facility Name (If not institution		er)	4b. City, Town, or I		h	4c. County of Deal	
			6101 Tuckerm		Age (In yrs. last birthday		ville If Under 24 Hrs	8. Date of Birth	Montgo	hplace (State or Foreign
	Funeral Director		5. Social Security Number 577 72 1201	10 <b>3</b> tM 2□F	74 Yrs.	Months Days	Hours Min.	(Month Day	10 1932	Korea
265			Usual Residence of Decedent		74			Tebruary	10 1552	ROZEG
	ehow	. [	10a. State 10b. County	/	10c. City, Town or L	ocation				10d. Inside City Limits
	a Ma	ctor	Maryland Mont	gomery	Rockvill	е				1 ☐ Yes 2 No
	er 28	Director	10e. Street and Number			10f. Zip Code		10	Og. Citizen of What Co	ountry?
	ath w	rai	6101 Tuckerman			208			USA	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland I of Heelin and Mental Hygiene. I of Heelin and Mental Hygiene. If item 271e marked other than "natural", or Items 23a or 28e-f ehow of item 271e marked other than "natural" or other treumatic event, the Madical Examinar must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Mai  3 □ Widowed 4 □ Divorce	If Yes Give	<b>X</b> No	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 🛣 No		to Rican, etc.)	14. Race - Ame Black, Whit Specify: As	e, etc.
ŏ	2 hou	ted		nt's Education	16a. Dece	dent's Usual Occupa	ion		16b. Kind of Business	Industry
215	within 7 ene. then "n	ple	(Specify only higher Elementary/Secondary (0-12)	est grade completed)  College (1-4	life.	kind of work done do DO NOT use retired)	iring most of wo	rking		
21	filed wil Hygien ther th	Completed		5+		hysician			Medical	
nd	d oth	Be	17. Father's Name (First, Middle,	, Last)				me (First, Middle, M	faiden Sumame)	
Maryland 21215-0036	2 should be filed within and Mental Hygiene. Ie marked other then eumatic event, tre M	၉	Sung Il Lee					ok Ahn		
Jar	2 sh and lem reum		19a. Informant's Name/Relation						City or Town, State, 2	Zip Code)
	permil. Pages 1 and 1 Depertment of Heelth Important: If item 27 any injury or other tr once.		Ina Lee / Wife	<u> </u>	20b. Place of Disp	Tuckerman	ı Lane R		Maryland 20c. Location - City or	20 <u>852</u> Town State
altimore,	Pages nert of P int: If ite		1   Burial 2 □ Cremation		comptant cro	matory or other place	1 1 1 1 1 1 1 1 1 1 1 1		coo. coolinate only of	Town, Glato
事	permit. Pag Depertment Important: I any injury c		4 ☐ Donation 5 ☐ Other (3		Norbeck	Memorial I 2. Name and Address			lney, Mar	
Ba	Depending Depending Import		Town t	Medica	an 1	1800 New I	ні lampshir	e Ave Sil	ldi Funera ver Sprin	MD 20904
*	hysician /Medical		a. Part1. En r the disease, o shock, or eart failure. Lis lmmedia: a case (Final disease or condition resulting in death)	t only one cause on eac	sed the death. Do not en h line.  MOSCIENO as a consequence of):	, .	, such as cardia	}	disease	Approximate Interval Between Onset and Death
	sate be executed was hysicien and hysicien and the burial-transit each	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	as a consequence of): as a consequence of):					,
P.O. Box 68	e death certific the ettending p hed for use as I	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		n 2 ∏Fetal death 3[ at at time of death 5[	□Ectopic pregnancy □ Other (specify)		91	23d. Date of de Month	livery Day Year
rds, P.	w requires that the been signed by should be detac	٥	Part II. Other significant condit	ions contributing to deal	th but not resulting in the dem En	inderlying cause give	n in Part I.	23e. Did tob	acco use contribute to s 2 No 3 □ Pi	the cause of death?
I Records,		Completed						24a. Was ar autops perform 1 Yes 2	v prior to	utopsy findings available completion of cause of
of Vital	Physician: r this certifica ral director, I	Be	25. Was case referred to medical examiner?					ath (Check only one	9)	
) Jc	Physic this c	ဥ	1 Yes 2 No	Hospital:			4   Nursing r		nce 6 Other (Spe	cify)
Ž.	en e	on:	27. Manner of Death 1 Natural 5 ☐ Pendi		Injury 28b. Time ( Day Year) Injury	Work	at ? es 2 □No	28d. Describe ho	w injury occurred	
Ä	or Attendation death Director: in by the	Certification;	3 Suicide 6 Could	mined 289. Place of	f Injury - At home, farm, si , etc. (Specify)		es 5   NO	28f. Location (Str City or Town	reet and Number or Ri , State)	ural Route Number,
_	To the Hospital within 24 hours and to the Funeral completely filled	edicai C	29a. Certifier 1 Certifyi (Check only 2 Medica	ing Physician: To the bit I Examiner: On the basi and manner	est of my knowledge, dea is of examination and/or in r stated.	th occurred at the time	e, date and place inion, death occi	e, and due to the ca urred at the time, da	use(s) and manner as ate and place, and due	s stated. e to the cause(s)
	omple	Me	29b. Signature and title of certific		1 .	29c. License	number	29	9d. Date signed (Mont	h, Day, Year)
			Palain	Tomska	Man ma	DS	1916	0	ctohen	23 2006
	5		30. Name and address of person Patricia Toms	ko Nay. 1	1119 Rockvi	Print) Pike	G-10	O, Roc	kville, 1	MD 20852
	Sta Registi	200	31. Date filed (Month, Day, Year OCT 2	4 2006	gistrar's Signature	arti		1		

		-	- State Amend #18 p	State of Mer phys/f							ygiene Reg. No.	1116	35552
			Decedent's Name (First, Middle, Las.	")						2. Date of I	Death Day	Year	3. Time of Death
Е	Physicia /Medic		Margery S Lillar	:d						Octobe		2006	4:00 P M
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Tow	n, or Locat	ion of Death	h	4c. (	County of Death	1
			Frederick Memori					erick				rederio	
	Funeral Director		233-32-1700	x	7 4	ast birthday) Yrs.	If Under 1 Ye Months Da		nder 24 Hrs. Irs Min.	JULY	2.7 ear)	9.32 Sintr	nplace (State or Foreign untry) WV
	pue A	-	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation			<del>-</del>			10d. Inside City Limits
	Maryli f eho	ŏ	MD MONTGO	MERY	1		SVILLE						1 Yes 2 □ No
	sa or 28e-	Il Director	10e. Street and Number 18111 BARNESVI	LLE ROAI	)		10f. Zip Coo 208				_	en of What Co	untry?
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mentai Hygiene. Item 27 is marked other then "natural", or items 23s or 28e-f show other traumatic event, the Medical Exercitive count for notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1  Yes 2 1	•	li li	Vas Decedent Yes, specify ( ☐ Yes 2 💢	Cuban, Me	o Origin? (S xican, Puert city:	pecify Yes or I to Rican, etc.)		4. Race - Ame Black, White Specify: WH	o, etc.
8	hour fural		15. Decedent's Ed	Year or Dates:		16a. Deced	lent's Usual O	cupation			16b. Kin	d of Business/l	ndustry
1215	within 72 ene. then "na he Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12)		5+)	(Give life. L	kind of work do DO NOT use re SEWIFE	ne during tired)	most of wo	rking		MESTIC	
Maryland 21215-003	d be filed ental Hygia ced other c event, II	To Be C	17. Father's Name (First, Middle, Last)  CREE G. SWIGER						other's Nar	me (First, Midd FORD		<sub>Sumame)</sub> Ashcraf	t
ary	shoul and M mari	۲	19a. Informant's Name/Relationship (7			19b. Mailin	g Address (St	eet and N	ımber or Ri	ural Route Nun	ber, City or	Town, State, Z	ip Code)
	and 2 lath a lath a r 27 io		J. ROBERT LILLA	RD/SPOU	SE	P.O.	вох 3	65,	BARN	ESVILI	E, M	D 208	38
ore	of He of He fiten		20a. Method of Disposition  1     Burial 2 □ Cremation 3 □	Removal from State	C	emetery, cren	sition (Name of natory or other	f place)	1	Date		cation - City or	
Ĕ	Pages iment of t		4 ☐ Donation 5 ☐ Other (Specify	)	MT	. OLI			1	24/06	FRE	DERICK	, MD
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		21. Signature of Funeral Service Licen	,			P. O.	N FU	NÉRA 86	L HOME	VILL	E, MD	20838
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that cause one cause on each I	d the death ine.	n. Do not ent	er the mode of	dying, suc	h as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
7	Physician		Immediate Cause (Final disease or condition resulting in death)	a COLON	CAN	ICER							SYEARS
	/Medical Examiner		Todaking in coultry	Due to (or as	a consequ	uence of):							
	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequ	uance of):							
8760,	cate be executed physicien and the burial-transit	al Exar	that initiated events resulting in death) Last	Due to (or as	a consequ	uence of):							
687	phys phys s the	dical		d									
Вох	that the death certific ed by the ettending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mg/ms? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	Ideath 3□	Ectopic pregn Other (specif		4		_ 2	3d. Date of deli Month	very Day Year
ds, P.O.	88 E B	þ	Part II. Other significant conditions o	ontributing to death	out not resi	uiting in the u	nderlying caus	e given in F	Part I.		d tobacco u:		the cause of death?
Ö	w requir been si should	etec	-							24a. W	hs an	24h Were au	tonsy findings available
l Re	The lav	Completed								au	topsy rformed	death?	topsy findings available completion of cause of 2 No
/ita	ician: Th certificete rector, pag	Be (	25. Was case referred to medical examiner?	Harrison -					Place of De	ath (Check onl	у опе)		
<b>d</b>	this al di	P.	1 ☐ Yes 2 ☐ No  27. Manney of Death	Hospital: 1 Impat		ER/Outpatier 28b. Time of			☐ Nursing I	dome 5 ☐ Re		Other (Spec	cify)
00	Attending Physician: r death. sctor: After this certification of the funeral director.	tion	1 ☑Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ay Year)	Injury	м 200.	injury at Work? 1 ∐ Yes	2 🗆 No	200. Descrit	o now injury	Occurred	
Division of Vital Records,	i gite	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir	ijury - At ho tc. (Specif		eet, factory, of	fice			(Street and Town, State)		ral Route Number,
_	the Hospital hin 24 hours a the Funerei I npletely filled	Medical C		ysician: To the bes niner: On the basis and manner s	of examina								
	To the within 2. To the complete	Me	29b. Signature and title of certifier					cense num			29d. Date	e signed (Monta	h, Day, Year)
	F > F 0			MD			Do	1056	314		CETOE	3ER 23	, 2006,
	20		30. Name and ddress of person who BINDU GEORGE		death (Iten 46	n 23a) (Type.	Print)	JOHN	isoni	DRIVE	FRE	DERICK	, 2006 . - MD21702
	Sta Regist		31. Date filed (Month, Day, Year) OCT 2 4 2	32. egis	trar's Signa								

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 35553 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Year 7:30 2000 /Medical 4a. Fecility Name (If not institution, give stree 4b. City, Town, or Location of Death 4c. County of Death Examiner OWER Hill Dav54 Domerset If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Hours 1 M 2 XE 213-44-0138 Director 30-1945 Bryn News, Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner roughts notified at MD 1 Yes 2 No Completed by Funeral Director OWER omerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 21871 7571 11.S.A Log of death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Black "naturel", or than "nature". It's Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ath and Mental Hygiene.

27 is marked other than 'r traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 1244 aborer ttome maker 17. Father's Name (First, Middle | ast) 18. Mother's Name (First, Middle, Maiden Sumame) Be Health and Mental veadu 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဂ္ 19a. Informant's Name/Relationship (Type, Print) nt of Health a : If item 27 is or other tra SON Morris 2300 12 SE Washington De 20 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition **⊘**Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If eny injury or once. ben EZER Cemetery 10-28-2006 Mayumsco, MD
22. Name and Address of Facility Anthony E. Ward Functor Home \* 4 ☐ Donation 5 ☐ Other (Specify) permil. 21. Signature of Funeral Service Licensee And Lung & World & 36639 Hampder Are Prince 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 30639 Hampden Are. Princess Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL Physician INTARCTION /Medical Due to (or as a consequence of): Examiner 4SCVD Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transil Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physiclan/Medical he as attending IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown á signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be RR HOSIS OF LIVER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? Yes 25 No certificate 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1XYes 2 No this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred within 24 hours after death. To the Funaral Director: After Attanding 1 Xvatural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 1 6 D 48098 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KARUMBUNATIAN VITAY MO 2/8/ HALL HGWY CRISFIELD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINĀL

			1 - For Stata Registrar	State of Ma	aryland		irtment of F tificate of		l Mental Hy	giene Reg. No	(UUb	35554
	Physici	an	1. Decedent's Name (First, Middle, Las	·					2. Date of De	_	y Year	3. Time of Death
	/Medic	al	William R. Mul  4a. Facility Name (If not institution, give				4h Cibi Taura	-1	Octobe		, 2006	7:40 P. M
	Examir	er	Calvert Memorial	· ·		ĺ	4b. City, Town, o	Frederi			Calvert	
	Funeral				(In yrs. last	birthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of Bir	th	9 Birthr	lace (State or Foreign
	Director		373-30-0263	JM 2□F -	76	Yrs.	Months Days	Hours Mi	March	12,	1930 Mar	yland
	and ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Loc	ation					Od. Inside City Limits
	Many -1 ehe	tor	Maryland Calvert		C+	Leona	rd					1 ☐ Yes 2X No
	or 28a	Director	10e. Street and Number	·	St.	TIGOLIO	10f. Zip Code			10g. Cit	izen of What Cour	ntry?
	23a c	aiD	6501 Quiet Court				20685			Uni	ted State	es
	tems	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?		13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? an, Mexican, Pue	(Specify Yes or No arto Rican, etc.)		14. Race - Americ Black, White,	an Indian,
36	ilied within 72 hours after death with the Maryland Hygiene. ther then "nature!", or Items 23a or 28a-f ehow int. Ite Medical Examinar must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 🖫 Widowed 4 ☐ Divorced	1 XYes 2 □ N If Yes, Give Year or Dates: I	0 Zamaa	1	☐ Yes 21XNo	Specify:			Specify:	
Š	2 hou		15. Decedent's Ed	ucation		6a. Deced	ent's Usual Occup	ation		16b. K	ind of Business/in	nite
212	be filed within 72 ho ital Hygiene. Id other then "natui event, Ita Medical	Completed	(Specify only highest grades) Elementary/Secondary (0-12)	de completed) College (1-4or 5-	+)	(Give I life. D	ind of work done of NOT use retired	during most of w f)	orking			,
7	filed wi Hygien other th	Con	12		D	irect	or of Pu					te Manageme
Maryland 21215-0036	9 E 5 X	Be	17. Father's Name (First, Middle, Last)						ame (First, Middle			
<u>=</u>	should be ind Menta marked umatic ev	၉	William F. Muller  19a. Informant's Name/Relationship (7)			10h Mailin	Address (Street		ed Brown: Rural Route Numb			2-1-1
_	and 2 sealth ar n 27 le		Terrence A. Sunst	,								and 20678
Š.	- I 9 =		20a. Method of Disposition			-	ition (Name of atory or other place		Date		ocation - City or To	
Ĕ	Pages nent of I ant: If its ury or o		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify				ns Cemet		31/06	Che	ltenham	Maryland
Baltimore,	permit. Pages Depertment of Important: If it eny injury or o once.		21. Signature of Funeral Service Licen	99		22.	Name and Addres	ss of Facility	Rausch Fi	ınera	al Home,	P.A.
_	20 5 e d	-	367.50	<del></del>					oad, Port F		ic, Maryla	and 20676
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final									Approximate Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	a. Meteste	tic N	ton Juga	all cell	CONTINON	a of th	. c (	ung	Crisci and Douti
	Examiner			Due to (or as a	i consequen	ce of):						
		ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequen	ce of):						
	ocuted nd transi	Examiner	that initiated events	C								
Ď,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a	consequenc	ce of):						
08/80	law requires that the death certificate be execut as been signed by the attending physician and 2 should be detached for use as the burial-train	edicai		d						<u>_</u>		
X OX	leath certific attending pl	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o	of pregnancy			1,000			23d. Date of delive	70
ă	death e atte	Physician/M	in the past 12 months? 1 □ Yes 2 ⊠ No	1 ☐ Live birth 2 4 ☐ Pregnant at t			Ectopic pregnancy Other (specify)			1		Day Year
5	at the by th	hys	9 Unknown	9□ Unknown								
s,	res th igned be de	<u>م</u>	Part II. Other significant conditions co	ntributing to death but	t not resultin	g in the und	derlying cause give	en in Part I.			se contribute to th	3/
ecords,	requi	eted							101	/es 2[	No 3 Prob	ably 4 Unknown
e E	hast hast 3e2s	Completed							24a. Was autop	an sy rmed?	prior to con	psy findings available appletion of cause of
U	n: Th ficate or. pag	ပိ	25. Was case referred to medical						1 ☐ Yes	22 No	death? 1 ☐ Yes	28 No
5	ysicle s certi	To Be	examiner?	Hospital: 12 Inpatien	t 2 🗆 EB/	Outpatient	3□ DOA Othe	-	eath <i>Check only o</i>	- 100	. Coh (0 (	
DIVISION OF	ng Ph ter thi		27. Manner of Death  1 Valural 5 □ Pending	28a. Date of Injury (Month, Day	28t	. Time of Injury	28c. Injury Work		28d. Describe h			)
<u> </u>	eath. or: Af	catic	2 ☐ Accident investigation	(,,	, , ,			res 2 □ No				
2	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At home, (Specify)	farm, stree	et, factory, office		28f. Location (S City or Tow		d Number or Rural	Route Number,
_	pitel ours a eral [		29a. Certifier 1D/ Certifying Phy	reicien. To the best of	lea acciden	des dest						Ţ.
	To the Hospitel or Attending Physicien: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director. page 2 should be detached to make the funeral director.	edical	(Check only 2 Medical Exami	sician: To the best of iner: On the basis of e and manner state	examination	and/or inve	estigation, in my op	e, date and plac pinion, death occ	e, and due to the durred at the time, of	date and	and manner as sta place, and due to	ated. the cause(s)
	within To th	¥	29b. Signature and title of certifier	151		3	29c. License			29d. Date	signed (Month, L	Day, Year)
			1 Dord	y Imaly	b W-		04	,		001	ober 2:	5, 2006
3	3+1		30. Name and address of person and of	ompleted cause of der	ath (Item 23a	a) (Type, P	PO P	rince	Frederi	CIC	- mei	20118
P	Stat		31. Date filed (Month, Day, Year)	32. Registra	Signature	11100			• • • •			
	Registra	ir	OCT 2	6 2006	Police	K	Books 1					

Please Type or Print in Black Indelible Ink

dgar A. Machi		Amend Fate of Many 2861	Department of Certificate of	Health and Death	Mental F	lygiene R	eg. No. 200	06 35555
Physic Wedical Exam		Edgar Alexander Machuca				2. Date of Dea Month October 2		3. Time of Death 1838 hrs
		Shady Grove Adventist Hospital		4b. City, Town, or L Rockville	ocation of Deal		4c. County of Montgome	
Funeral Director			(In yrs last birthday)	If Under 1 Year Months Days	If Under 24Hi Hours Mii	s. 8. Date of Bir n. 06 05/25	/1078	9. Birthplace (State or Foreign E1 Country) Salvador
any		Usual Residence of Decedent	Oc. City, Town or Locat	<u> </u>		05/25	/19/0	10d Inside City Limits
<b>*</b>	ctor	Maryland Montgomery  10e. Street and Number	German	town	·	<del>- 1</del>	0-04	1 X Yes 2 No
with the Maryland ns 23a or 28a-f sho be notified at once	al Director	24109 Ridge Road		208	876		0g. Citizen of What El Salvad	•
fter death	by Funeral	3 Widowed 4 Divorced If Yes, Give Year	No If Y	s Decedent of Hispa es, specify Cuban, I Yes 2 No	Mexican, Puert		White, e	American Indian, Black, etc. White
5-0036 led within 72 hours a Hygiene. other than "natural the Medical Examin	Completed b	45 5 4 6 5 4 4 6	) during m	t's Usual Occupation ost of working life. Doner			16b. Kind of Busin Constru	•
MD 21215-0036 2 should be filed within 7 h and Mental Hygiene. 27 is marked other than matic event, the Medica	o Be Co	17. Father's Name (First, Middle, Last)  Juan Antonio Machuca  19a Informant's Name/Relationship (Type, Print)	10h Mailine	·	Blanca	Machuca		
MD 2 and 2 shou ealth and N em 27 is n	È	Maria Elena Portillo/wife	Germa	.ntown, Ma	aryland	<u>, 20876</u>	ber, City or Town, S	
Baltimore, MD 21215 permit. Pages I and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked o injury or other traumatic event, th		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify	20b. Place of Disposi crematory or oth Family Cem	er place)		Date 30-2006	20c. Location - Cr	•
	y (	21. Signature of Funeral Service Licensee  Wanda C, Bacon CC	36/ 34	47 14th S	Street,	N.W. Wa	Funeral shington,	Mome, Inc. D.C. 20010
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a Multiple Injuries  Due to (or as a consequ		e mode of dying, su	uch as cardiac d	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
ed issit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of the consequen						
O, e be executed /sician and burial - transit	edical	UNPENDED AMENDED						
30x 6876 death certificate ne attending phy I for use as the b	Physician/Me	IF FEMALE: 23b Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome 1 Live birth 4 Pregnant at tim 9 Unknown	2 Feta	er (Specify)	Ectopic pregna	ncy	23d. Date of deli Month	ivery Day Year
S, P.O. nires that the signed by d be detach	ð	Part II. Other significant conditions contributing to death be	ut not resulting in the ur	nderlying cause give	en in Part I.			e to the cause of death?  Probably 4 Unknown
Division of Vital Records, P.O. It the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Completed	25 Was case referred to medical				24a. Was al autops perform 1 V Yes 2	y prior ned? death	
Yita Physician r this cer al directe	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient	2 <b>V</b> ER/Outpatient	3 DOA Oth	Death (Check of her Nursin		Residence 6 O	ther:
Sion of Attending Phe death.  ctor: After to the funeral	ation:	27. Manner of Death  1 Natural 5 Pending 2 ✓ Accident Investigation	28b. Time of Inj 1742 hrs		L	28d. Describe ho Driver auto a	ow injury occurred uto collision	
Divis ospital or A hours after of uneral Direct y filled in by	Certification:	3 Suicide 6 Could not be determined (Specify) Cocal				or Town, Sta Ridge Road a	<sup>ate)</sup> and Skylark Ro	Rural Route Number, City ad, Germantown, M
To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check only one) 2 Medical Examiner on the sist of examiner and Manner stated	nowledge, death occurre ation and/or investigatio	n, in my opinion, de	eath occurred a	due to the cause t the time, date a	(s) and manner as s nd place, and due to	started. o the cause(s)
	2	29b. Signature and title of certifier		29c. License n			29d. Date signed ( October 22, 20	
2(3)		30 Name end address of person who completed cause of deat Pamela E. Southall, MD Assistant Medica		Penn Street, E	Baltimore, M	ID 21201		
St Regist		31. Date filed (Month, Day, Year) CT 2 5 2006 Registrar's S	Signature Special	7				

		-	For State Registrar	State of N	Maryland	-	artmen rtificate			and M		jiene		6	35556
	Physicia		Decedent's Name (First, Middle, I  LOUISE	Last) MOS	T.FV					ľ	2. Date of Dea Month	Da		ear	3. Time of Death
	/Medic	al -	4a. Facility Name (If not institution, g				4b. City.	Town, or	Location of	of Death	Oct.	16,	200 County of		10:05A <sup>M</sup>
	Examin	er	Friends Nurs		,				у Ѕр		3		Mont		nery
	Funeral Director		5. Social Security Number 212-38-0452  Usual Residence of Decedent	Sex 7. 1□M 2√F	Age (In yrs. Ia 99		If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day Nov • 24	, Year)	906		place (State or Foreign ntry) ryland
	yland yland		10a. State 10b. County	** ** ***	10c. City,	Town or Lo	cation								10d. Inside City Limits
	Sa-f et	Director	MD Mont	gomery		Sa	ndy S	Spri	ng						1 Xes 2 No
	with th		10e. Street and Number		_		10f. Zip					10g. Ci	tizen of Wha		•
	ns 23	Funerai	17712 Norw	OOd ROad		i. 13.	Was Deced		9860 Ispanic Ori	gin? (Spe	cify Yes or No-		U.S		
စ္က	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other than "neturel", or Items 23s or 28s-f show aumstic event, the Medical Examinar must be multified at	y Fun	1 Never Married 2 Married	Armed Force	s?		If Yes, spec 1 ☐ Yes		n, Mexican Specify:	, Puerto	icify Yes or No- Rican, etc.)		Black, Specify:	White,	etc.
ğ	hours turel',	ed by	3X Widowed 4 ☐ Divorced  15. Decedent's	Year or Date	s:		dent's Usua					16b K	ind of Busin		
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2	filed wit Hygiene other the	Corr	12th	``	,		Nurse	9						rto.	n Hospita
Maryland 21215-0036	m = 0 \$	o Be	17. Father's Name (First, Middle, La Robert Phoe						18. Mothe		(First, Middle, elena				
ary	should and Me umath	ဥ	19a. Informant's Name/Relationship			19b. Maili	ng Address	(Street a	and Numbe		I Route Numbe			ate, Zij	Code)
	and 2 ealth a m 27 is		Paul F. Scot	t, Jr. (	(Nephe				rwoo		100				g,MD 2086
ore.	ages 1 or of H or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3		ce:	ace of Dispo metery, crea .ual	matory`or o	ther plac	9)		4/06		ocation - Ci		own, State ing , MD
Baltimore,	permit. Peges 1 and 2 should be Department of Health and Menta Importent: If Item 27 ie marked any injury or other traumatic er	ı	4 Donation 5 Other (Spe	1	Muc			_							ome, PA
Ã	Depa Depa Impo any i		CENTE /	,Dull	den										MD20850
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that cause on each	sed the death. h line.	. Do not en	ter the mod	e of dyin	g, such as	cardiac o	r respiratory ar	rest,			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	- u.	oke										2 hours
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	D E	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		as a consequi										Z MOGED
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89	artificat ing phy e as th		IF FEMALE:					-				-1		.1	
P.O. Box	es that the death certific igned by the attending p be detached for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		n 2 ☐ Fetale tat time of de	death 3[	∃Ectopic pr ∃ Other (sp						23d. Date of Month		ery Day Year
	that the	/ Ph	Part II. Other significant condition	s contributing to deat	h but not resul	Iting in the u	inderlying c	ause givi	en in Part I		23e. Did to	bacco	use contrib	ute to 1	the cause of death?
rds	w requires been sign should be	ed by									1 🗆 Y	es 2	□No 3	☐ Pro	bably 4 Unknown
l Records,	Attending Physician: The law requires that the death certificate be executed rideath. ector: After this certificete has been signed by the attending physicien and by the tuneral director, paga 2 should be detached for use as the burial-transit	Completed				7							prio	or to co ath?	opsy findings available ompletion of cause of
Vita Vita	ician: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				Oth		of Death	(Check only o				
ō	Phys	7: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of (Month,	atient 2 🗆 E Injury	ER/Outpatie 28b. Time o		8c. Injun	4p(vi	-	me 5 Resid				fy)
lon	ath. ath. or: Afte	ation	1 Natural 5 Pending 2 Accident investiga	tion	Day Year)	Injury	м		k? Yes 2 🗍	No					
Division of Vital	j	Certification:	3 Suicide 6 Could no 4 Homicide determin	ad 289. Place of	Injury - At hor , etc. (Specify)	me, farm, st	reet, factory	, office			28f. Location (S City or Tow	treet a m, Stat	nd Number e)	or Rur	al Route Number,
	To the Hospital or Attending Physician: The lawithin 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier Check only one) Certifying	Physician: To the be caminer: On the basi and manner	is of examinati	vledge, deat ion and/or in	th occurred evestigation	at the tin , in my o	ne, date ar pinion, dea	nd place, ath occurr	and due to the o	ause(s date ar	and mann d place, and	ner as s d due t	stated. to the cause(s)
		Σ	29b. Signature and title of certifier	W1:	F1.	0 11 1	290		e number	2		29d. Da			Day, Year)
	3		30. Name and address of person w	ho completed cause	of death (lear	W 1	(I)	D	4332	3			10/2	40/	υb
			Abeda Aliki	nan, M.D	. 1082	20 Hi	ckor	y R	idge	Rd.	, Colu	umb	ia, N	/ID	21044
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) OCT 2 4 2	2006 39. Reg	gistrar's Signat	ure	de)								

		For	Please I			nd / Depa	artment of F rtificate of	lealth a		ental Hyg	iene	005		5558
70		1 - State Registrar	mt Middle Inst				uncate of	Deain	-	2. Date of Deat	g. N <del>ó</del>			ne of Death
Physi /Med	cian	1. Decedent's Name <i>(Fir</i> Clyde	St, Middle, Last) McG							October	18,		1:	:00 A M
Exam		4a. Facility Name (If not	institution, give s	street and nur	nber)		4b. City, Town, o	or Location o	f Death		4c. C	ounty of De	ath	
		Washington					Takoma		04 Han		Mo	ntgom		
Funera Directo	n .9	5. Social Security Number 433-92-822	4 87	M 2□F	7. Age (In yrs	. (ast birthday) Yrs.	Months Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, Jan. 9,	<sup>Year)</sup> 195	. (	irthplace (St Country) uisial	ate or Foreign na
aryland ahow	7		o. County			ity, Town or Lo	ocation							de City Limits Yes 2 ☐ No
r 28e-f	Director	Maryland 10e. Street and Number	Prince G	eorges	В	owie	10f. Zip Code			1	0g. Citize	n of What (	Country?	
h with	a D	7903 01d Ba	arn Road				20715				Unit	ed St	ates	
deat	Funerai	11. Marital Status		12. Was Dece Armed Fo	edent Ever in l	J.S. 13.	Was Decedent of H	Hispanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	14	Race - An Black, Wi	nerican India	ın,
ING 21215-0036  be filed within 72 hours after death with the Maryland ital hygiene. Ind other than "natural", or items 23a or 28e-f ahow event, the Medical Examinat must be notified at	þ	1 ☑ Never Married 3 ☐ Widowed 4 ☐		1 ☑ Yes If Yes, Giv	2 No 197	76-	1 ☐ Yes 2XX No				s	pecify: B1		
215-0 nin 72 ho n natur Medical	Completed	15. (Specify o Elementary/Secondar	Decedent's Edu nly highest grade	cation e <i>completed)</i> Coflege (1	I-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most	t of workir	ng		of Busines		
d with	E	5	y (0 12)			Lands	scaping	,			Gar	denin	g	
Maryland 21215-0036 nd 2 should be filed within 72 hours aff the and Mental Pylgiene. Ith and Mental Pylgiene. 27 ie markad other than "natural", or treumatic event, the Medical Exert	To Be C	17. Father's Name (First								(First, Middle, Mayne	Maiden Si	ımame)		
vre, Marylan s 1 and 2 should be if Health and Mental item 27 ie markad other trsumatic ev	-	19a. Informant's Name/	Relationship (Ty		- \		ng Address (Street				City or 1		, Zip Code)	
Ballimore, IM perrit. Pages 1 and 2 Department of Health Important: if item 27 i		Tonia D.  20a. Method of Disposit  1 ⊠Burial 2 □ Cr	ion	(niec	20b.	Place of Dispo	Old Barn osition (Name of matory or other pla			ate			or Town, Sta	te
Pag ment ant:		4 Donation 5			Max		ational Cem	etery	2006			el, Mar		
P P P P P P P P P P P P P P P P P P P	S S	21. Signature of Funera	I Service Licens	99			2. Name and Addre							2
m goes	a	Une	dre's	though	sson		7400 Geor					D.C.	2001	
Physicia /Medica	al	23a. Part1. Enter the d shock, or heart fai Immediate Cause (Fina disease or condition resulting in death)		. Lu	caused the dealer line.	can	ter the mode or dyl	ng, such as	cardiac o	r respiratory arre	est,		Onset	and Death
760, te be executed XI ysicien and burial-transit yellow	cai Examiner	Sequentially list condition in any, leading to immediate cause. Enter Underlyin Cause (Disease or injust that initiated events resulting in death) Last	ons, diate g	<b>c</b> .	(or as a conse		Jusio T						10/	7/106
Box 68 death certifica e ettending ph	Physician/Medi	IF FEMALE:  23b. Was decedent pre in the past 12 mor 1  Yes 2 No 9 Unknown	nths?	1 Live b	tcome of preg birth 2 Fe nant at time of own	taf death 3	□Ectopic pregnand □ Other (specify) _	÷у			23	d. Date of o	delivery Day	Year
_ <u> </u>	þ	Part II. Other significar	nt conditions co	ntnbuting to d	eath but not re	esulting in the u	ınderlying cause gr	ven in Part I.			oacco use		to the cause Probably	e of death? 4 XJUnknown
of Vital Records, P.O Physicien: The law requires that the this certificate has been signed by th ral director, page 2 should be detache	Completed									24a. Was a autops perform	v	prior t death	o compfetior	lings available n of cause of
Vital F vicien: Th certificete rector, pag	Be (	25. Was case referred examiner?	-						of Death	(Check only on	Θ)			
of Vita Physicien: this certific	2	1 ☐ Yes 2XXNo	1			☐ ER/Outpatie	nt 3L DOA			ne 5 Reside			pecify)	
VISION O Attending Ph death. cetor: After th y the funeral		27. Manner of Death 1 ⊠Natural 5 2 □ Accident	Pending investigation	28a. Date (Mon	of Injury oth, Day Year)	28b. Time of Injury	Wo	iryat ork? ]Yes 2 ☐		28d. Describe ho	ow injury	occurred		
effer in b	Certification:	3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	28e. Place build	of fnjury - At ing, etc. (Spec	home, farm, st	reet, factory, office			28f. Location (Si City or Town		<b>Number</b> or	Rural Route	Number,
Hospitel 24 hours Funerel stely filled	edical C	(Check only one)	Certifying Phy Medical Exami	iner: On the b	a best of my k easis of exami ener stated.	owladge, daa nation and/or ii	m oncurred at the to exestigation, in my	ime date in opinion, dea	th occurre	and fue to the co ed at the time, d	tuse(s) tate and p	nd manner lace, and d	as stated ue to the ca	use(s)
To the vithin 2 Comple	Me	29b. Signature and title	of certifier	i	<u>-</u>		$\mathcal{D}$	se number 456	01		101	18/1	onth, Day, Ye	,
, ,		30. Name and address	of person who o	pmpleted cau	se of death (It	em 23a) (Type	Print)	12.	Ta	koma	Pa	nk,1	uD:	20912
AND SECTION AND SE	State strar	31. Date filed (Month, L	7 <b>2 4</b> 200		Registrar's Sig	COV nature	vile							,

			1 - For State of Maryl		artment of F			giene () (	16	35559
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Earl Samuel Miller Jr				2. Date of Dea 10-25	- 2006	Year	3. Time of Death 12:45a <sub>M</sub>
	Examin		4a. Facility Name (If not institution, give street and number) 15406 National Pike		4b. City, Town, o	r Location of Death Stown,		4c. County Wash		on
	Funeral Director		217-16-2190 XDM 2□F 83	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 8 - 9 - 1	923	9. Birthpl Coun MD	lace (State or Foreign try)
	faryland show	or	1	. City, Town or Lo					10	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the has or 28a-1	Direct	10e. Street and Number 15406 National Pike		10f. Zip Code 217	40		10g. Citizen of V		
396	72 hours after death with the Maryland natural', or itams 23a or 28s-1 show digal Exacilher: ast De trofflied at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in Armed Forces?  1 Never Married 2 Married  11. Marital Status  12. Was Decedent Ever in Armed Forces?  1 Never Married 12 New Married  12. Was Decedent Ever in Armed Forces?  1 Never Married 12 New Married Porces?	7TT	Was Decedent of Hif Yes, specify Cuba		pecify Yes or No- pecify Yes or No- perior Rican, etc.)	14. Rac	e - America k, White, e hite	ato
Maryland 21215-0036	within ane. than "	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12th grade  College (1-4or 5+) 0	(Give	dent's Usual Occup kind of work done DO NOT use retired dealer	nation during most of world)	king	16b. Kind of Bu		•
/land	2 should be filed and Mental Hygis Is markad other aumatic evant, II	To Be C	17. Father's Name (First, Middle, Last) Earl Samuel Miller Sr.			18. Mother's Nam Edith	e (First, Middle, O Fors		re)	
	and 2 should lath and Men alth and Men 27 Is marks er traumatic		19a. Informant's Name/Relationship (Type, Print) Pauline Miller wife	19b. Mailir 1540	ng Address <i>(Street</i> 6 Natio	and Number or Ru nal Pike	ral Route Number e Hager	r, City or Town, stown,	State, Zip MD	<sup>Code)</sup> 21740
Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other once.		20a. Method of Disposition  1 □ ♣ urial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)	b. Place of Dispo cemetery, crer Pau	osition (Name of matory or other place I Cemete	ery Oct	. 21,	20c. Location - Clear		
Balt	permit. Departu Imports any int		21. Signature of Funeral Service Licensee  Laniel 0. Junely	$\mathcal{H}$	P.O.BOX	Edwin Th 310 Cle	ar Spr	ing. M	al H D 21	ome, Inc
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the caused shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Due to (or as a condition	leath. Do not ent	ter the mode of dyir	ng, such as cardiac	or respiratory arr	rest,		Approximate Interval Between Onset and Peath
8760,		ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a condition of the cause) Due to							
.O. Box 687	atter for 1	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unknow	etal death 3	□Ectopic pregnancy □ Other (specify) _	′		23d. Dat Mor	e of deliver	ry Day Year
Ω.	requires that the di leen signed by the hould be detached	by	Part II. Other significant conditions contributing to death but not		nderlying cause giv	en in Part I.	23e. Did to			e cause of death?
Vital Records,	The law ate has b page 2 s	Completed					24a. Whas a autops perform	med? c	rior to com leath?	sy findings available apletion of cause of 2 No
of	ding Phyalclan: Th n. After this certificate funeral director, pag	on: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending  28a. Date of Injury (Month, Day Yea	2 ER/Outpatien 28b. Time of fnjury	f 28c. fnjur Wor	er: 4 Nursing He y at k?	th (Check only on ome 5 Residence 28d. Describe he	ence 6 Othe		)
Division	or Attendition of Att	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - 4 building, etc. (Sp.			Yes 2 □No	28f. Location (Si City or Town		er or Rural	Route Number,
	a Hospital 124 hours a a Funeral I	edicai C	29a. Certifier (Check only one)  10 Certifying Physicien: To the best of my 2 Medicel Exeminer: On the basis of exame and manner stated.	nination and/or inv	vestigation in my o	ninion death occur	red at the time d	ate and place a	and due to	the cause(s)
	To tha To tha To tha Comple	Me	29b. Signature and title of confiler	>	29c. Licens	e number 2680	6	9d. Date signed	Month, E	7006 27742
0	1041		30. Name are ress of person corn and cause of death (	Item 3a) (Type,	Print) Conico	She	14040	Nan	M	SYCK
5.1	Sta Registr		31. Date filed (Month, Day, Year)  32. Signstrar's Sig	gnature -	ede		J			

			For State Registrar	State of I	Maryland		artment rtificate			and Me	ental Hy	giene Reg. Ne	2005	35	560
			Decedent's Name (First, Middle, Last	st)							2. Date of D	eath	·		ne of Death
	Physici		ANNA REBECCA	MARTZ							OCTOBI	ER 23	y 2006	9:3	37 P™
	/Medic Examin		4a. Facility Name (If not institution, give		er)		4b. City, 7	Town, or	Location of	of Death		4c	. County of Dea	ıth	
			FAHRNEY-KEEDY MEM						ONSB					INGTO	
	Funeral Director		216-14-5900	ex 7. □M 20XF	Age (In yrs. I	ast birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	Min.	8. Date of Bi (Month, D JAN • 1	av, Year)		thplace (St ountry) MARYLA	ate or Foreig AND
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City	r. Town or Lo	ocation							10d. Insid	de City Limits
	Aanyla f sho	ō		CTON				T.	BOONS	R∩P∩					Yes 2XNo
	28a-	Director	MARYLAND WASHIN  10e. Street and Number	GION			10f. Zip		DOOLING.	borto		10g. Cit	tizen of What C	ountry?	
	3a or	٥	8507 MAPLEVILLE R	OAD					2171	3			U.S.	Δ.	
	ms 2	Funerai	11. Marital Status	12. Was Decede	ent Ever in U.S	S. 13.	Was Deced	ent of His			cify Yes or N Rican, etc.)	0-	14. Race - Am	erican India	ın,
350	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "netural", or items 23s or 28s-f show event, the Medical Exerction rout be indified at	by Fur	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Date	X No		1 □ Yes 2	_	Specify:	i, Pueno F	tican, etc.)		Black, Whi	TO, OTC. WHITE	
ž	2 hou		15. Decedent's Ed			16a. Dece	dent's Usua	l Occupa	tion	t adadelm	_	16b. K	ind of Business	Industry	
9500-612	filed within 72 Hygiene. sther then "nei ent, the Medic	Completed	(Specify only highest gra	de completed)  Cotlege (1-4)	or 5+)	life.	kind of wor DO NOT us	k done d e retired)	uring mosi )	r or workin	g				
7	ge wil	Соп	8			LICE	ISED P	RACI	-			-	JRSING 1	HOME	
Maryland	be filed ital Hygi d other	Be (	17. Father's Name (First, Middle, Last)								(First, Middle		-		
<u>X</u>	should be and Mental amarkad o	To	JAMES WESLEY WHIP			1					ZABETI				
혈	12 sh h and 7 Is rr reurr		19a. Informant's Name/Relationship (				•	•				•	or Town, State,	,	1712
_	as 1 and 2 should b of Health and Ment (Itam 27 is marked r other treumatice		JAMES E. MARTZ/SO  20a. Method of Disposition	N	20b. PI	324 1			CIRC		ate SOON2BC		MARYLAI ocation - City of		L713
وّ			1 XBurial 2 ☐ Cremation 3 ☐			emetery, crei	matory or ot	her place			10001				
Baitimore,			* 4 □Donation 5 □ Other (Specifical Service Vicer	1	BOO	NSBORC	CEME  Name and			-	/2006		NSBORO,		LAND
g	permit. Departr Importe any Inju		I Tout Mil		m. Dea		ST FU			ME /			itional <u>Maryla</u> i		.713
	_		23a. Part . Enter the disease, or som	plications that cau	sed the death	n. Do not ent	er the mode	of dying	, such as				riat y tai	Approx	imate
	Physician		shock, or heart failure. List only Immediate Cause (Final	^	at.										Between and Death
	Physician /Medical		disease or condition resulting in death)	d	as a consequ	-								(0	<del></del>
	Examiner			cen		as < w	lar,	A cr	12	1				5	×
L		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ				- A	/				/	
	cuted nd iransi	Examiner	that initiated events	c											
Š	e exe ien a urial-		resulting in death) Last	Due to (or	as a consequ	uence of):									
8/60	cate be executed ohysicien and the burial-transit	dicai	•	d											
×	ding p	a l	IF FEMALE:	23c. If yes, outcome	me of pregnal	nev							02d Date of de	li.e.	
ROX	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	by Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth	1 2 ☐ Fetal t at time of de	death 3[	Ectopic pre						23d. Date of de Month	Day	Year
o.	at the de by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknow		1111									
J.	res that signed b be deta	y Pt	Part II. Other significent conditions	ontributing to deat	h but not resu	ulting in the u	nderlying ca	use give	n in Part I.		23e. Did	tobacco i	use contribute t	o the cause	of death?
g	quires n sign										1 🗆	Yes 2	□No 3□P	robably 4	<b>r∌</b> Unknown
Hecords,	aw require s been sig	Completed									24a. Was		24b. Were a	utopsy findi	ngs available
	The Iz te ha	Eo									auto perf	ormed? 22 No	death?	2 □ No	of cause of
Vital		a)	25. Was case referred to medical						26. Place	of Death	(Check only				
		To B	examiner? 1 ☐ Yes 25 No	Hospital: 1 ☐ Inp	atient 2□l	ER/Outpatier	nt 3 DO	A Othe	r: 47 Nu	rsing Hom	ne 5 ☐ Res	idence	6 □Other (Spe	ecify)	
Division of	ng Pl		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of I (Month,	njury Day Ye <i>ar</i> )	28b. Time o Injury		Bc. Injury Work	?		8d. Describe	how inju	ry occurred		
<u>S</u>	eath. or: A the fu	catio	2 Accident investigation				М	1 🗆 1	'es 2 □ I						
Ë	or Att	Certification:	3 Suicide 6 Could not be determined	200. Flace 01	Injury - At ho , etc. (Specify	me, farm, str	eet, factory,	office		2	8f. Location ( City or To		nd Number or R o)	ural Route i	Vumber,
	pitel ours al		29a. Certifier To Certifying Ph	voicion. To the he	ant of mustings	utedge doet	h coourred o	at the tim	e date an	d place, as	nd due to the	cauco(c'	and manner a	e etated	
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.	edicai	29a. Certifier Certifying Ph (Check only one) 2 Medical Exam	viner: On the basi and manner	s of examinat	ion and/or in	vestigation,	in my op	inion, deal	th occurre	d at the time,	date and	d place, and du	e to the cau	se(s)
	o the o the omple	Me	29b. Signature and title of certifier	1			29c.	. License	number			29d. Da	te signed (Mon	th, Day, Yea	31)
	⊢₃⊢ŏ		) al	/				D	523	23		10	1-24-	06	
			30. Name and address of person who	completed cause of	of death (Item	23a) (Type.	Print)	1	/				,		
H	-4		Khalid Waseem,		1126 0			Hage	rsto	vn. M	larvlar	nd 2	21740		
	Sta		31 Date filed (Month, Day, Year)	32. Reg	istrar's Signat	ture									
	Registr	ar	OCT 262	UUD	(Espa)_)	D. 1.	marked	*							
				-											

DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and Me	ental Hygien	e 2006	35561
			1- State Registrar amended 1 per DR. 10-26-06 Certificate of Death CCHD	AS Reg. N	lo.	3. Time of Death
	Physici	an	1. Decedent's Name (First, Middle, Last) Jeffrey Lynn Masten	Month E	Day Year	21015 2 4
	/Medic		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		23, 2006 tc. County of Deat	
1.	Examin	er	The Johns Hopkins Hospital Baltimore			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) ff Under 1 Year If Under 24 Hrs. 8	I. Date of Birth (Month, Day, Yea	ir) Co	nplace (State or Foreign untry)
	Director		222-32-2858 12m 20 5 8 Yrs.	day 7, 19	48 De	laware
	and and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	<del></del>		10d. fnside City Limits
	Many 1 sh	to	Delaware Kent Dover			1 ☐ Yes 2 No
	r 28a	Director	10e. Street and Number	10g. (	Citizen of What Co	untry?
	23a c	ralD	453 Chesthut Grove , 11101		USA	
	itsms	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Ame Black, White	
36	n 72 hours after death with the Maryland "natural", or itsms 23e or 28e-f show sidical Eserillet mall be nyillied at	by F	1  Never Married 2  Married		Specify: W	hite
215-0036	2 hou atura		15. Decedent's Education 16a. Decedent's Usual Occupation	16b.	Kind of Business/	Industry
215	c 2 2	Completed	(Specify only highest grade completed)  [Give kind of work done during most of working life. DO NOT use retired)  [Give kind of work done during most of working life. DO NOT use retired)		ealth	Care
2	be filed within 72 ho ital Hygiene. Id other than "natui svent, I'ra Medical	S	17 Father's Name (First Middle Last)  18 Mother's Name (First Middle Last)			
Maryland	should be filed within and Mental Hygiene. marked other than imatic event, the M	Be	El de			ochan
Z	2 should be and Mental is marked o	ို	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural I			· · · · · · · · · · · · · · · · · · ·
S	od 2 is		Callye Master 148 Moor farm.	Hartly	De	19953
Je,	of Health Item 27		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	1 2	Location - City or	-
altimore,	it. Pages rtment of I ortant: if its njury or o		1 Deligible 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Box routes Chapel 1012	7/06 F.	rederic	a, De
Balt	permit. Pag Department Important: i any njury o				uneral	Chapel
	0.0 ≥ <b>€</b> Ø		23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or a		ver, De	Approximate
			shock, or heart failure. List only one cause on each line.			Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Acute Kessiratory Distress  Due to (or as a consequence of):	synon	rome	10147
	Examiner		300015	,		: 10.15
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that signated executed.)			1
	ecuted ind transi	Examin	that instracted events			14601
8760,	cate be executed physicien and the burial-transit	al E	resulting in death) Last  Due to (or as a consequence of):			32 years
687		edical	d.			3,103
Box (	leath certific attending p i for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of deli	very
	death e atte	Physician/Me	in the past 12 months?  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  1 ☐ Yes 2 ☐ No  9 ☐ Unknown		Month	Day Year
P.0	that the de ted by the a detached t	hys	9 Unknown	257 /		
	8 20	۵	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1 Tyes	11	the cause of death?
Ö	w require been si should t	eted		24a. Was an	10	topsy findings available
Records,	The law sete hes page 2.4	Completed		autopsy performed?	prior to death?	completion of cause of
Vital		a a	25. Was case referred to medical 26. Pface of Death (	1 Yes 2	No 1 □ Yes	2□ No
Ž	S 5	To B	examiner?  1 Yes 2 No Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	e 5 ☐ Residence	6 □Other (Spec	city)
n of	ding Ph h. After th funeral		27. Magner of Death 28a. Dife of Injury 28b. Time of 28c. Injury at 28 time of 1 Netural 5 □ Pending (Month, Day Year) Injury Work?	d. Describe how in		
sio	ten leat tor: the	catl	2 Accident Investigation M 1 Yes 2 No	f. Location (Street	and Number of Re	rent Bouto Number
Division	i or Attend after death Director: /	Certification;	4 Homicide  3 Source  4 Homicide  4 Homicide  4 Source  4 Source  4 Source  4 Source  4 Source  4 Source  5 Source  5 Source  6 Source  6 Source  6 Source  6 Source  7 Source  7 Source  8 Source  8 Source  1 Source	City or Town, Sta		rai Hobie Womber,
_	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by		29a. Certifier 1 Certiflying Physician: To the best of my knowledge, death consurred at the time, date and place, an	d due to the cause	(e) and manner as	stated
	he Ho in 24 I he Fu pletely	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.			
	To t To t	Σ	29b. Signature and title of certifier  1 C V fr (16 5 29c. License number		Date signed (Month	n, Day, Year)
			D60211		toper !	13,2006
			30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)  OHAMN BRANDES GOO NORTH WOLFE STR	EET BA	LTIMORE	MARYLAND
7	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature			. / / / /
-4	Regist		OCT 2 6 2006 Jane 13 Months			

			For State Registrar	State of Ma	ryland	I / Departme Certifica			Mental Hy	giene Reg. No.	2006	35562
E	Physici	an	1. Decedent's Name (First, Middle, Las	" - NA	$\bigcirc$	20.0			2. Date of De		X995	3. Time of Death
	/Medic Examin	al	Aq. Facility Name (If not institution, give	street and number)	<u> </u>	Ab. Cit	y, Town, or	Location of Dea	UCTOD	4c,	County of Deal	4 1 1 1 0
	- ZAGIIIII		Chester Rive	c Hospi	tal	Center Che	sterk	wn		14	rent	
H	Funeral Director		5. Social Security Number 6. S 214–14–2728	ex 7.*Age ☐M 2.2XF	(In yrs. Ia:	Month	er 1 Year s Days	Hours Min		'' 1921	9. Bird	hplace (State or Foreign multry)  MD
2			Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Location						10d. Inside City Limits
Mary	fied at	tor	MD KENT			K HALL						1 □Yes 2Ã No
ith the	or 28	Funeral Director	10e. Street and Number				Zip Code				zen of What Co	ountry?
of the of	ne 236	eral	6060 HYNSON ROAD	12. Was Decedent E	ver in U.S		661 sedent of His	panic Origin? (	Specify Yes or No	USA - 1	14. Race - Ame	rican Indian,
ING 21215-0036 he filed within 72 hours after death with the Maryland	is thygiene.  do ther than "naturel", or lieme 23s or 28s-1 show event, the Medical Examinar must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:	•	If Yes, sp	ecify Cubar 2 XNo	i, Mexican, Pue	rto Rican, etc.)		Black, Whit Specify: WH	e, etc.
15-0 22-23-24	natur	leted	15. Decedent's Ed (Specify only highest gra			16a. Decedent's Us (Give kind of v life. DO NOT	vork done di	iring most of we	orking	16b. Kir	nd of Business	Industry
717	r then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	-)	HOMEMAKE				OWN	N HOME	
Maryland 21215-0036		To Be C	17. Father's Name (First, Middle, Last) EDWARD F. HART						me (First, Middle DR B. PA		Sumame)	
Maryla 12 should	2 - 2 - 1		19a. Informant's Name/Relationship (MADELYN RENI/NEI)	• • • • • • • • • • • • • • • • • • • •		19b. Mailing Addre						Zip Code)
	or other		20a. Method of Disposition			ice of Disposition (A	ame of	-	Date		cation - City or	Town, State
Baltimore,	Department Important: If any Injury or once.		1 Burial 2 Coremation 3 4 Donation 5 Other (Specify	()	CHE	SAPEARE <sup>®</sup> C			1//2006	STEV	ENSVIL	LE, MD
<b>8</b>	Department in poor		21. Signature of Funeral Service Licer	elfente	in	FELLO 130 S	PEER I	ELFENBE KOAD, ÇI	HESTERTO	WN, M	funeat D 2162	L HOME, PA
	nysician /Medical xaminer		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	MO	and Ang	Pu	Such as cardia	C or respiratory a	rrest,		Approximate Interval Between Onset and Death
BOX 6876U,	physicien end the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c								
	e attending of for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal	death 3 Ectopic				2	3d. Date of del Month	ivery Day Year
ecords, P.O.	n signed by the a	þ	Part II. Other significant conditions of	ontributing to death but	not result	ting in the underlying	cause give	n in Part I.	23e. Did			the cause of death?
VITAL RECORDS	_ <u> </u>	Completed							24a. Was auto perfo		24b. Were au prior to death?	topsy findings available completion of cause of
/Ital	certificete rector, pag	BeC	25. Was case referred to medical examiner?						ath (Check only		10 165	2,0,010
o d	his	- To	1 ☐ Yes 2 No  27. Manner of Death	Hospital: 1 Inpatien 28a. Date of Injury		R/Outpatient 3 [] [		4 🗆 Nursing	Home 5 Resi			cify)
VISION	death. ctor: Afte y the fune	atlor	1 Natural 5 Pending 2 Accident investigation	1	Year)	Injury M	28c. Injury Work 1   Y	? es 2 □No		,,,,,,		
5 5	rs effer death. al Director: After t	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At hom (Specify)	ne, farm, street, facto	ory, office		28f. Location ( City or To			iral Route Number,
]	within 24 hours effer To the Funeral Directional Completely filled in by	Medical	29a. Certifier Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of niner: On the basis of e and manner state	examinatio	fledge, death occurre on and/or investigation	d at the time on, in my opi	e, date and plac nion, death occ	e, and due to the urred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
Toth	within To th compl	Me	29b. Signature and title of certifier			2	9c. License	number	30.	29d. Date	signed (Monti	n, Day, Year)
	5		Mulast	reus.	<b>S</b>		7	x678	54	10	16-6	)(q
ית	ns		30. Name and address of person who	2 120	CIA	staten	COCO	WO.	Wil	LiAn	n Tra	AINOR
	Sta Registr		31. Date filed (Month, Day (1681)	7 2008 <sup>2. Registrar</sup>	's Signatu	ire & Son	de		V	- 1		

State of Maryland / Department of Health and Mental Hygiene 006

1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 18 **Physician** 2006 0 10 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner montgomer park entist akoma 0 M If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6 Sex 5. Social Security Number **Funeral** 1⊠M 2□F ar Director (A Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a, State Items 23a or 28e-f ehow the Medical Examiner must be notified at 1 XYes 2 No Funeral Director ont OMERY 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 209 venue death v 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Ite 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify þ 90 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) infan 0 traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last, Be lum OWa ပ္ 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Depirtment of Health at Important: If Item 27 is any injury or other traiting. Silver-Spring Md. 20910 Tumba N land nayl adine 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Carroll f 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Md \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Washington Adventist Hosp ) CUSVOIT 7600 Avei Talcoma 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Wmpnar /Medical mins Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit be executed Due to (or as a consequence of): Box 68760. the attending physicien Physician/Medical law requires that the death certificate the as IF FEMALE use a 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day Month Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. | detached 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 99 3 Probably 4 □Unknown 2 No 1 Tes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1 No 1 ☐ Yes 2 No 1 Yas certificate or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one, funeral director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient P 3 DOA 1 ☐ Yes ZMrNo 1 Minpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 Natural 1 Tyes 2 \Bo investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospitel c within 24 hours aff To the Funerel Di 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 25706 Kriacm 20 no completed cause of death (Item 23a) (Type, Print) 30. Name and address of person w Washington-Atveni Registrar's Signature Year) 31. Date filed (Month 32. State 9 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** M 29 Charles Stanley Morgan 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10XM 2□ F Months Yrs. Director 168-34-1815 June 18.1943 PA Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits worde in then "natural, or iteme 23a or 28a-f ehover the Medical Examinar must be notified at 1 Yes 2 No Director MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12519 Huyett Lane **USA** 21740 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 end 2 should be filed within 72 hours after rent of Health and Mental Hygiene.
ant: if item 27 ie marked other then "natural", or ite mary or other traumatic event, tra Nexistal Easth any or other traumatic event, tra Nexistal 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 🏋 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hauling 10 Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lloyd Stanley Morgan ၉ Hilda Ellen Gordon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melody Morgan/Daughter 621 West Washington Street Apt.2F Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Antioch Cemetery 11/01/06 Big Cove Tannery, PA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute esperation mar her PARIMONIC /Medical Due to (or as a consequence of): Examiner Gargere of Sequentially list conditions, if any, leading to inimisorate cause. Enter Underlying Cause (Disease or injury Examiner use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed phenol Usculo disease Per that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical ettending for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Certification: To his 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending in Hosping.
In 24 hours after death.
the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Hosp within 24 ho To the Fund completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 038764

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21742

30. Name an address of perso o completed cause of death (Item 23a) (Type, Print)

mis mid

32 Resistrar's Signature

KAR P. RIGGE, MA

31. Date filed (Month, Day, Year) NOV: 0 9

Mr Get

Certificate of Death

MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OCT 2 4 2006 >

MD

32. Registr

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1. Decedent's Name (First, Middle, Last)

DONALD

**Physician** 

State of Maryland / Department of Health and Mental Hygiene Reg. NZ UU6 2. Date of Death 2006 4c. County of Death REDERICK 8. Date of Birth (Month, Day, Year) 7-03-6 9. Birthplace (State or Foreign Country)

WASHINETONAC 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: BLACK 16b. Kind of Business/Industry AUTO V. MCBRIDE Columbia S.C. 20c. Location - City or Town, State Smithsburg 22. Warme and Address of Facility 64ry L. Rollins Fuetral Hone FRODERICK MO 21701 Approximate Interval Between Onset and Death 23d. Date of delivery Year Month Dav 23e. Did tobacco use coptribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed 2 No 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene $2006$
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		ı	1 - For State Registrar	State of Marylan	d / Depa		Health and I	Mental Hyg	_	_	35566
	Dhuaisi		1. Decedent's Name (First, Middle, Last)	-				2. Date of Dea Month		Year	3. Time of Death
п	Physicia /Medic		Elaine Renee Nu	ssbaum				October	21,	2006	10:15P. м
	Examin		4a. Facility Name (If not institution, give s Crofton Convalescent an			Croftor			A <sup>-</sup>	nne Ar	
	Funeral Director		5. Social Security Number 070-18-6029 6. Sex	7. Age (In yrs. 83		If Under 1 Year Months Days		May 30, 1	923	9. Birth Con Broi	place (State or Foreign intry) New York
	Maryland -f show	tor	10a. State 10b. County Virginia Prince Wi		y. Town or Lo	ocation					10d, Inside City Limits 1 ☐ Yes 2 ☐ No
	h with the 23a or 28a	al Direc	10e. Street and Number 12853 Gentle Shade	Drive		10f. Zip Code 20	136	1		of What Cou	
036	n 72 hours after death with the Maryland *natural; or items 23s or 28s-f show exical Evantiner must be notified at	by Funeral Director	11. Maritat Status  1 ☐ Never Married 2 ☐ Married  3 ※ Widowed 4 ☐ Divorced	2. Was Decedent Ever in U Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII		Was Decedent of lif Yes, specify Cut	Hispanic Origin? (S pan, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)		Race - Amer Black, White pecify:	
0-CLZ	filed within 72 ho Hygiene. other than *natur ent, If e Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)			pation during most of wood)			of Business/l	
7	ygien ygien t, t.	So	12		Admir	istrativ	e Assista				vernment
₾ .	should be fill ind Mental H is marked oth umatic svsn	To Be	17. Father's Name (First, Middle, Last) Benjamin Beryl Ben				Besse Fe	ne (First, Middle, I eigenbaun	n		
	s 1 and 2 sh if Heelth and itsm 27 is m other trsum		19a. Informant's Name/Relationship (Ty) Steven Kronthal -n	ephew	12853	3 Gentle	shade Dr	ive Brist	ow, '	Virgin	ia 20136
Baltimore,	0 0 == ==		20a. Method of Disposition  1X Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)			osition (Name of matory or other pla orial Gard		Date 24/2006		y, Mar	
Bait	permit. Pag Department Important: It sny injury o		21. Signature of Funeral Service License	- Eward		naid V 400 Powde	Borgward er Mill R	t Funeral oad Belts	l Home	e, PA e, Mar	yland 20705
	nysician	0. 7	23a. Part1. Enter the disease, or compli shock, or heart failure. List only or Immediate Cause (Finat disease or condition	cations that caused the deat ecause on each line. Lung Cand		ter the mode of dy	ing, such as cardia	or respiratory arr	est,		Approximate Interval Between Onset and Death Vears
	/Medical Examiner		resulting in death)	Due to (or as a conseq Chronic (	uence of):	ctive Pu	lmonary D	isease			years
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-	icate be executed physicien and s the burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Dementia  Due to (or as a conseq	uence of):						years
P.O. Box 68	the death certif y the attending ached for use as	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	□Ectopic pregnand □ Other (specify) _	ey .		230	l. Date of deli Month	very Day Year
rds, P	w requires that been signed b should be deta	d by PI	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	inderlying cause gi	ven in Part I.				the cause of death?
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Vital	rtific clor,	Be (	25. Was case referred to medical examiner?				26. Place of De	ath Check only or	(e)		
<u>&gt;</u>	hysic hysic hysic	10	1 ☐ Yes 2 📉 No	ospital: 1   Inpatient 2	ER/Outpatie	nt 3 DOA	her: 4 Nursing H	lome 5□Reside	ence 6	Other (Spec	ufy)
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DIX	tei or Att rs efter de st Dirsct ed in by t	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, st	reet, factory, office		28f. Location (S City or Town	treet and N n, State)	lumber or Ru	ral Route Number,
	To the Hospitel or Attending Physicien: within 24 hours elter death as the certifice To the Funersi Director: Attenthis certifice completely filled in by the funeral director, to	Medical	29a. Certifier 11 Certifying Physical Check only 2 Medical Examination	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, deat tion and/or in	th occurred at the to extra the total the tota	ime, date and place opinion, death occu	urred at the time, d	ate and pla	ace, and due	to the cause(s)
1	To T withi	Σ	29b. Signature and Hitte of Pertifier	sh a	100	29c. Licen D201	se number _08	2		igned (Month Der 23	
	~		30. Name and address of person who co Rakesh Arora, M.D.	mpteted cause of death (Iter 14300 Gallar	n 23a) (Type, nt Fox	Lane,#22	1 Bowie,	Maryland	1 207:	15	
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signa	ture /	ente					

		1	For State Registrar	State of N	Marylan		artment of H		ind Mei		iene ,g. No? () (	16	35567
			Decedent's Name (First, Middle,	Last)					2.	Date of Deat	Day	Year	3. Time of Death
	Physicia /Medic		Albert Hobert	Nelson_					0	ctober	27, 20	06	12:50PM
	Examin		4a. Facility Name (If not institution,	give street and numbe	ər)		4b. City, Town, or	Location of	of Death		4c. County		1
			Dennett Road Ma				Oakland If Under 1 Year	If Under 2	24 Hrs o	Date of Birth	Garre		place (State or Foreign
	Funeral		5. Social Security Number 233-58-3069	3. Sex 7 1 1 1 M 2 □ F	Age (In yrs. I 71	as <i>t birtnday)</i> Yrs.	Months Days	Hours	Min.	(Month, Day,	Yeer)	COL	Virginia  Virginia
	Director	-	Usual Residence of Decedent		/1				A	pr. 24,	1933	West	
	ylanc		10a. State 10b. County		10c. City	y, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	e Ma	cto	WV	Grant		1	Mount Sto	rm					
	ith th	Funeral Director	10e. Street and Number				10f. Zip Code	06700		11	0g. Citizen of \		untry?
	• 23e	rai	HC 76, Box 510	12. Was Decede	at Ever in II	6   12		26739	nin? (Specif	v Yes or No-		SA e - Amer	ican Indian,
	ter de Item	ŭ,	11, Marital Status  1 ☐ Never Married 2 ☐ Marrie	Armed Force	s?	.5.	Was Decedent of Hi If Yes, specify Cuba	in, Mexican	, Puerto Rio	can, etc.)		ck, White	
99	urs af	5	3 ☐ Widowed 4 🛣 Divorced	If Yes, Give Year or Date	s:		1 ☐ Yes 2 💢 No	Specify:			Specify	·· W	hite
21215-0036	within 72 hours after death with the Maryland one. one. Than "natural" or Iteme 23a or 28a-f ehow the Moviest Examiner must be notilised at the Moviest Examiner must be notilised at	Completed	15. Decedent's (Specify only highest	Education		16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most	t of working		16b. Kind of B	usiness/l	ndustry
7	ithin 19.	npie	Elementary/Secondary (0-12)	College (1-40	or 5+)			1)	·		C======	C	t
7	led w lygier her th		17. Father's Name (First, Middle, L	act)			Butcher	18 Mothe	er's Name (	First Middle M	Groce		tore
Maryland	ntal H ed ot	Be	Samuel	- Nels	on				ary			Nels	on
<u>\frac{1}{2}</u>	thould id Me mark matic	ဥ	19a. Informant's Name/Relationsh			19b. Maili	ng Address (Street	and Numbe	er or Rural F	Route Number	, City or Town,	State, Z	îp Code)
<b>≥</b>	nd 2 s llth ar 27 is r trau		Thelma Aronhalt			HC 7	6, Box 51	0, Mo	unt S	torm, V	Vest Vi	rgin	ia 26739
<u>a</u>	s 1 ar		20a. Method of Disposition			Place of Dispo	osition (Name of matory or other place	(e)	Dat	θ :	20c. Location	City or 1	Fown, State
Ë	Page nent o int: If		1 ☐ Burial 2 🖾 Cremation  4 ☐ Donation 5 ☐ Other (Sp		170		rematory		11/2/0	06 N	lorgant	own,	WV
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural" or Iteme 23a or 28a-f show Important: If item 27 is marked other than "natural" or Iteme 33a or 28a-f show Important; If item 27 is marked other than "natural" or Iteme 33a or 28a-f show Important in Item 3		21. Signature of Funeral Service L	Censar			2. Name and Addrest tewart Fu		Home	32 S. S Oakla	Second and, MD	St. 21	550
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that cause on each	sed the deat h line.	h. Do not en	ter the mode of dyin	ig, such as	cardiac or r	espiratory arre	est,		Approximate Interval Between Onset and Death
20	Pnysician		Immediate Cause (Final disease or condition	acute	pulmo	nary e	dema						15 minutes
	/Medical Examiner		resulting in death)	Due to (or	as a conseq	uence of):							
	Examine	L	Sequentially list conditions,		stive as a conseq		failure						6 months
	ted nsit	nju	cause. Enter Underlying Cause (Disease or injury				ardiovas	cular	disea	ase			l year
	be executed iician and burial-transit	Examiner	that initiated events resulting in death) Last	U	as a conseq								
760,	ate be executed hysician and the burial-transit	cai		d									
89	tificat ng phy as th		15.551.41.5										
Вох	death certifica e attending ph d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	me of pregna	l death 3	⊒Ectopic pregnancy	,				ite of deli	very Day Year
		sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnan 9□Unknow	it at time of d n	leath 5[	Other (specify)						,
P.0	requires that the de neen signed by the hould be detached		Part II. Other significant condition	s contributing to deat	th but not res	ulting in the u	inderlying cause giv	en in Part I.		23e. Did tol	bacco use con	tribute to	the cause of death?
ds,	se G e	d by	dementia			•				1 🗆 Ye	es X No	3 🗆 Pro	obably 4 Unknown
20	w requir been si should I	Completed								24a. Was a	n 24b.	Were au	topsy findings available
Re	has has	dmo								autops perform	med?	death?	completion of cause of 2⊡ No
ta		a	25. Was case referred to medical					26. Place	e of Death	Check onl on	-AL INO		22.70
of Vital Record	S S	To B	examiner? 1 ☐ Yes 2 <b>X</b> No	Hospital: 1 ☐ Inp	atient 2	ER/Outpatie	nt 3 DOA	<sup>1⊖Г:</sup> 4 [X] Nu	ursing Home	5 ☐ Reside	ence 6 □Oth	ner (Spec	cify)
			27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	Wor			d. Describe ho	ow injury occur	red	
Sio	Attending or death. ector: After by the fune	catic	2 Accident investig	ation ot be				Yes 2□		v 1 (C	to a set to see all the come	haras D.	ıral Route Number,
Division	는 HE C	Certification:	4 Homicide determi	and 286, Place of	i Injury - At h i, etc. <i>(Specii</i>	ome, farm, si fy)	reet, factory, office		28	City or Town		שר זוי זפנ	irai noute ivuilibei,
	urs urs eral		29a. Certifier 1XXCertifying	Physician: To the b	est of my kno	owledge dea	th occurred at the tir	me date an	nd place, an	d due to the c	ause(s) and m	anner as	stated.
	To the Hoepital of within 24 hours at To the Funeral D completely filled it	Medical	(Check only 2 Medicel E	xaminer: On the bas and manne	is of examina	ation and/or in	vestigation, in my o	pinion, dea	ath occurred	d at the time, d	late and place,	and due	to the cause(s)
	To the within 2 To the comple	Μe	29b. Signature and title of certifier			4/1	29c. Licens	e number		2	9d. Date signe	d (Monti	h, Day, Year)
	, - 0		Allen	Harna	-	MI	D002	5759			ctober	27,	2006
		0	30. Name and address of person				. Print)						
		$\prec$	Walter K. Nauma				7, Accide	nt, M	D 21	520			
		ate	31. Date filed (Month, Day, Year)	1 2006 <b>3</b> 2. Reg	gistrar's Sign	ature A	1						
	Regist	rar	<b>V</b> O. 0	1000	of the s	Car A	Books o						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006 35568 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 1:32 PM **Physician** 2006 George Edward Newton /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Atlantic General Hospital Berlin Worcester If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Min. Hours X∏M 2□F 83 142-16-4773 N.J. Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County rai', or itame 23a or 28a-f show Examiner must be notified at 1 XIYes 2 No Director MD Worcester Berlin 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 17 Sundial Circle 21811 USA death \ Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after M Yes 2 No 1941-1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 🍇 ☐ No Specify: Specify: White þ 3 Widowed 4 Divorced 1946 "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than I've Ma Elementary/Secondary (0-12) College (1-4or 5+) Secretary/ Treasurer Electric Electrical Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be and Mental is marked Florence Leader George W. Newton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other treu once. Betty Newton 17 Sundial Circle, Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State \* 4 □ Donation 5 □ Other (Specify) 10/23/2006 Frankford, DE Cape Henlopen Crem. 22. Name and Address of FacilityThe Burbage Funeral Home Fundaj Service Licensee 108 William St., Berlin, MD 21811 23a. Part1. Enjor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DISSECTION AORTIC MINUTE **Physician** /Medical Due to (or as e consequence of): **Examiner** Y FARRY TBN 510 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown been signed by should be detacl 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò Records, 2 No 3 Probably 4 Unknown 1 🔲 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Vital Attending Physicien: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 FVOutpatient 1 Yes 2 No 3 DOA Medical Certification: To this Division of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After 1 Natural
2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation after death filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 6 within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 00063813

State

Registrar

30. Name and address of person who completed

DEVAN

31. Date filed (Month, Day, Year)

DOBBRACK

2006 4

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DUB 2/11/23 10/22/06

cause of death (Item 23a) (Type, Print)

me)

32. Registrar's Signature

PATURNE CEFTERING HOSPITAL, BRICIA, NO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 06 10 12 /Medical ta Facility Name (It not institution, give street and number)
Teninsula Regional Medical Center 4c. County of Death Examiner Wicomica If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 MM 2 □ F Months Country) Director Vecu 1939 filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show Idical Examiner must be notified at 1 ☐ Yes 2 No Director ew BACKVIlle CCOMACK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 37/01 U Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Tyes 2No Specify: þ Specify: White 3 Widowed 4 Divorced Completed Injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other trailmests. V504 Elementary/Secondary (0-12) CENTYA1 College (1-4or 5+) '√ S 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee HICKEN 23a. P. of. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner ACTIC VALVE REPLACEMENT Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Division or Vital 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: filled in by the 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title

To the H within 24 To the F Complete

William

State Registrar

DHMH 17 Rev 1/2001

Bluff

line

32. Segistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1000

OCT 2 4 2006

31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of M	laryland		ment of F		Mental Hyg	iene .g. n2 0 0 6	35570
			Decedent's Name (First, Middle, Last	st)					2. Date of Deat	th	3. Time of Death
	Physici		Bertha	Mae	Poole				Month	22, 2006	2:20 P. M
	/Medic Examin		4a. Facility Name (If not institution, give			45	o. City, Town, or	Location of Deatl		4c. County of De	
	Examili	er	Shady Grove Adver				Rockv				
	Funeral		5. Social Security Number 6. S		ge (In yrs. last		Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	Mont go	irthplace (State or Foreign Country)
	Director			□M 2⊠F	58	Yrs. M	onths Days	Hours Min.	(Month, Day, Aug. 1,	Year) (	Country) irginia
			Usuel Residence of Decedent						nug.1,	1740	LIGINIA
	ylan,		10a. State 10b. County		10c. City, T	own or Location	on				10d. Inside City Limits
	Mar.	to	Maryland Montgom	erv	Gai	thersb	uro				1 1 Yes 2 □ No
	r 288	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of What (	Country?
	3a.0	0	346 North Summit	Avenue. #	001		2087	7		United S	tates
	deeth	Funeral	11. Marital Status	12. Was Deceden	t Ever in U.S.	13. Was			pecify Yes or No- o Rican, etc.)	14. Race - An	nerican Indian,
(0	the state of the s	교	1X Never Married 2 Married	Armed Forces 1 ☐ Yes 2 🛭		1		ın, Mexican, Puert	o Rican, etc.)	Black, Wh	ite, etc.
ဗ္ဗ	urs a	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗆	Yes 2⊠ No	Specify:		Specify:	White
21215-0036	72 hours after deeth with the Maryland "natural", or Items 23a or 28a-f ehow salcal Exacilise must be nutilised at	Completed	15. Decedent's Ed		1	6a. Decedent	's Usual Occup	ation		16b. Kind of Busines	
72	100	pie	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or	54)	(Give kind life. DO l	d of work done i NOT use retired	during most of wor	king		
2	d within giene. or then	E	12	College (1-40)	3+)	Sales	s Clerk			Pharmac	v
D	at the	BeC	17. Father's Name (First, Middle, Last)	-		Darce	JOICIR	18. Mother's Nan	ne (First, Middle, M		<i></i>
au	2 to 5 to 5	ToB	Bordy	Nelson	Poole				Lockie	McVev	
7	should ind Men marke umatic	-	19a. Informant's Name/Relationship (			19b. Mailing A	ddress (Street	and Number or Ru		City or Town, State	Zip Code)
Maryland	tra tra		Dan D. Poole/ Bro	ther							MD. 20876
	s 1 an of Heal Item 2 other		20a. Method of Disposition	CHEL	20b. Place	e of Dispositio	n (Name of			20c. Location - City of	
ftimore,	nt of		1 ☐ Burial 2 ☑ Cremation 3 ☐		9	•	ory or other place	1	121 106	1 1	
逜	rtme rtan njur)		4 □ Donation 5 □ Other (Specify 21 Signature of Funeral Service Licen		Metro						, Virginia
Ba	permit. Pages of Depertment of Himportant: If Ite eny injury or ot once.	-	140-0	Mla	lelen				/ol Funer		.m 00077
	20204		200 Part Francisco		444-4-4-						MD. 20877
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each	line.	o not enter tr	ne mode of dyin	g, such as cardiad	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Pnysician	1	Immediate Cause (Final disease or condition	, Myocard	ial Inf	farctio	on				1 hour
	/Medical Examiner	- 4	resulting in death)	Due fo (or a	s a consequen	ice of):					
	Examine		Sequentially list conditions	b							
20.00	D =	ner	Sequenfially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	s a consequen	ice of):					
	ocute nd trans	Examine	Cause (Disease or injury that initiated events	c							
Ö,	te be executed ysicien and te burial-transit		resulting in death) Last	Due to (or a	s a consequen	ce of):					
68760,		Icai		d							
39	death certificat s ettending ph) d for use as th	Ved	IF FEMALE:								
Box	th ce rendi	an/	23b. Was decedent pregnant	23c. If yes, outcom- 1 □ Live birth	e of pregnancy 2 Fetal de		opic pregnancy			23d. Date of d	•
E	0 0 2	sici	in the past 12 months? 1 ☐ Yes 2 🖾 No	4□Pregnant a	at time of death		her (specify) _			Month	Day Year
P.0.	The law requires that the de ste hes been signed by ths c page 2 should be detached	Physician/Med	9 Unknown							i	
	igned be det	þ	Part II. Other significant conditions of		buf not resultin	ng in fhe under	rlying cause give	en in Part I.	23e. Did tob	pacco use confribute	to the cause of death?
of Vital Records,	w require been si should t		Diabetes, Hyperte	nsion					1 □ Y€	s 2 □ No 3 □ I	Probably 4 \Unknown
S	aw request been 2 should	Completed							24a. Was a		autopsy findings available
m	The lav	E							autops perform	ned? death?	completion of cause of
tal		0	25. Was case referred to medical	-				26. Place of Dea	ith (Check only on		3 2 110
>	0 v ip	ToB	examiner? 1 ☐ Yes 2∑ No	Hospital: 1 ☐ Inpat	ient 2 🔀 ER/	/Outpatient :	3 DOA Oth	00		ence 6 Other (Sp	ecify)
0	ding Phys h. After this funeral di	2	27. Manner of Death	28a. Date of Inj (Month, D	ury 28	b. Time of	28c. Injun			ow injury occurred	
<u>o</u>	Attending r death. actor: After by the fune	핥	1 Natural 5 Pending 2 Accident investigation		ay rear	Injury		Yes 2 □No			
Division	after deat Director; I in by the	1	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Ir	njury - Af home	, farm, street,	factory, office			reet and Number or i	Rural Route Number,
ă	al or	Certification;	4 - Homicide	building, e	etc. (Specify)				City or Town	n, State)	
	spits nours ners	ai	29a. Certifier 1 ☐ Certifying Ph	ysician: To the bes	t of my knowled	dge, death oc	curred at the tin	ne, date and place	, and due to the ca	ause(s) and manner	as stated.
	Ho Ho	edicai	(Check only 2 Medical Examone)	niner: On the basis and manner s	of examination tated.	and/or invest	igation, in my o	pinion, death occu	rred at the time, da	ate and place, and di	ue to the cause(s)
	To the Hospital of within 24 hours af To the Funers! D completely filled in	₽	29b. Signature and title of certifier		- M	1	29c. Licens	e number	29	9d. Date signed (Mo	nth, Day, Year)
			1 // localt	1	1 COX	MI	2	9300	(	DCTOBER	23 2006
	3		30. Name and address of person who	completed cause of	death (Item 22						
			Robert L. Gold, N					# 201	Rockvilla	e. MD. 208	50
	Sta	te	31. Date filed (Month, Day, Year)	32. <b>P</b> egis	trar's Signature	9 /		2019		- J - LUC	
	Registr		OCT 2 5 2	006	trar's Signature	Greek	EL .				

			1- For Amend #2 Per Phy gool 11	Depa Cer	rtment of Holding	ealth and N Death	nental Hyg	giene Reg. No. 2 (	006	35571
۰			Decedent's Name (First, Middle, Last)				2. Date of Dea Month		Year	3. Time of Death
	Physicia /Medic		MARION RAY PHILPOTT					er <del>21</del> , :	2006	4:15 a <sup>M</sup>
>	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County	of Death	
<b>8</b> .	9	-1	Heritage Harbor	( : ( ! )	Annapoli If Under 1 Year		O Data of Birth		Arunc	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day	, Year)	Count	* '
V.	Director		154-05-2920 85  Usual Residence of Decedent	110			6-14-1	1921	New .	Jersey
	land ow		10a. State 10b. County 10c. City, To	own or Loc	cation				10	0d. Inside City Limits
	Mary f sho	ŏ	Maryland Prince George's Hyat	tsvi	116					1 X Yes 2 □ No
	r 28a	Director	10e. Street and Number	COVI	10f. Zip Code			10g. Citizen of	What Coun	try?
	3a ol	O IE	7005 Barton Road		20784			U.S.A		
	deatl	Funeral	11 Marital Status 12. Was Decedent Ever in U.S.	13. V	Vas Decedent of His f Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No-		ce - America ck, White, e	
٥	after or ite		1 ☐ Never Married 2 ☐ Married I ☐ Yes 2 ☑ No If Yes, Give		i res, specify cubai I □ Yes 2X No	Specify:	riioan, etc.)	Specia		
500	ours rai", Exa	d by	3 ☑ Widowed 4 ☐ Divorced Year or Dates:		103 22110	opeony.			· • • • • • • • • • • • • • • • • • • •	ite
ก็	72 h 'natu	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usual Occupa kind of work done d	urina most of worl	ding	16b. Kind of E	lusiness/Ind	lustry
7	/ithin ne. han '	ם	Elementary/Secondary (0-12) College (1-4or 5+)		OO NOT use retired,			D (	٠.	
Z	iled w Hygie her t	ပိ	12 17. Father's Name ( <i>First, Middle, Last</i> )	Pnarr	nacy Cler	K 18. Mother's Nam	e (First Middle	Drug S		
and	ntal H	Be				_		maidon ourna	,,,,,	
ž	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	₽	Donald McCloskey  19a. Informant's Name/Relationship (Type. Print)	19h Mailin	g Address (Street a	Grace		er City or Town	State Zin	Code
M	d2sl than 7 is r traur									*
ຍົ	1 an Heal em 2				ortune P. sition (Name of		Date	20c. Location		
Бант	ages nt of t: If it		1 ⊠ Burial 2 □ Cremation 3 ⊠ Removal from State	etery, cren	sition (Name of natory or other place Ceme	tery	0.5 0006	111		•
	it. Purtue	1	4 □ Donation 5 □ Other (Specify) / Allow	ay Me	thodist Chu . Name and Addres	s of Facility Gas	25-2006	ALLOWA neral F	ly, NJ Jome	ΡΔ
g D	permil Depar Impor any ir		Adjust Holding		739 Balt				-	
			23a. Part1. Enter the disease, or complications that caused the death. I							Approximate
		S ()	shock, or heart failure. List only one cause on each line.							Interval Between Onset and Death
5	Physician / /Medical		disease or condition resulting in death)  Lung Cancer  Due to (or as a consequen	on of):						
	Examiner		Brain Metastas						- 1	
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause Litecas or min that initiated events							
	uted d ansit	Examine	cause. Enter Underlying Gause Literacy or hybrity that initiated events						- 23	
ລົ	executa and and and and and and and and and an	Exa	resulting in death) Last Due to (or as a consequen	ce of):						
0/2 0/2	the death certificate be executed y the attending physician and iched for use as the burial-transit	dical	d							
٥	ntifica ng ph as th	Med	IF FEMALE:							
ŏ n	th ce tendii r use	an/l	23b. Was decedent pregnant 23c. If yes, outcome pr pregnancy		Ectopic pregnancy			l l	ate of delive onth	ry Day Year
5	e des	sici	in the past 12 months? 1□ Yes 2⊡ No 4□ Pregnant at time of deat 9□ Unknown 9□ Unknown	h 5□	Other (specify)			"	OTTET T	Day Tour
7.	d by tetach	Physician/Me	Part II. Other significant conditions contributing to death but not resulting	a in the III	nderlying cause give	en in Part i	23e. Did to	ohacco use cor	tribute to th	ne cause of death?
Š,	sician: The law requires that the death certific certificate has been signed by the attending prector, page 2 should be detached for use as	þ	Tarrit. Street significant containing to dodar but not received	ig iii tilo di	identying oddee give	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		res 2 No		ably 4 ⊠Unknown
ecords	requ	Completed					-			
ě	e law has b	nple					24a. Was a autop	sv	prior to cor death?	psy findings available npletion of cause of
<u>=</u>	r: The licate ha							rmed? 2 No		2 🗆 No
VItal	I or Attending Physician: after death. Director: After this certifica I in by the funeral director, I	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	(O. A N	+ 3CLDOA Othe	26. Place of Dea				
ō	Physral di	은 -	27. Manner of Death 28a. Date of Injury 28	Bb. Time of	I SU DOA	441 Nursing H	ome 5 Resid			V)
	ding h. Afte fune	tion	1 ☒ Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury		k? Yes 2 ☐ No		, ,		
DIVISION	Atten deat ctor: y the	fica	3 Suicide 6 Could not be 28e. Place of injury - At home	, farm, str	eet, factory, office				ber or Rura	l Route Number,
2	after after Dire	Certification:	4 Homicide determined building, etc. (Specify)				City or Tow	vn, State)		
	spita nours nerai y fille		29a. Certifier 1K Certifying Physician: To the best of my knowle							
	To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the i	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and manner stated.	and/or in	vestigation, in my o	pinion, death occi	irea at the time,	date and place	, and due to	o tne causé(s)
	Vithii Voth	ž	29b. Signature and title of certified	$\wedge$	29c. License	number	02	29d. Date sign		Day, Year)
	~		ELCHTITANA, M	1)	1000	586	85	10/24,	2006	
. 1	1 (6)	'	30. Name and address of person who completed cause of death (Item 23							901
Λ	- 6		Richard Osei Akoto, MD, PC 3	44 W	. Univers	ity Blvd	#326,	Silver	Sprin	ng, MD
	Sta Regist		31. Date filed (Month, Day, Year) 22. Registrar's Signatur	Spen	de la companya della companya della companya de la companya della					

			For State Registrar	State of Maryland	l / Depa <i>Cei</i>	artment of F tificate of	leaith and Death	Mental Hy	giene Reg. No.	2006	35572
			1. Decedent's Name (First, Middle, Last)					2. Date of De	eath Day	Year	3. Time of Death
	Physici /Medic	_	Philip E.	Payne				Octob	per 2	26,200	
)	Examin		4a. Facility Name (If not institution, give s	street and number)			r Location of Dea	th		County of Death	
			308 Buena Vist		and the Control of the Control		1sburg	S Date of Bi		Caroli	
	Funeral		5. Social Security Number 6. Sex 217-28-3506 1 ☑	7. Age (In yrs. la 1 M 2 F 74	Yrs.	Months Days	Hours Min		ay, Year)	31 Mor	hplace (State or Foreign untry)
	Director		Usual Residence of Decedent					1101. 10	, 17	nai	yland
	ylanc		10a. State 10b. County	10c. City,	, Town or Lo	cation					10d. Inside City Limits
	Mar-fait	io	MD Caroli	ne	Feder	alsburg	5				1 🙀 Yes 2 🗍 No
	be filed within 72 hours after death with the Maryland nat lygiene. Id other than "natural", or flems 23a or 28a-f ahow avent, the Medical Evarings must be incitiled at	Director	10e. Street and Number			10f. Zip Code				en of What Co	
			308 Buena Vist				21632			ed St	
	er de	Funerai	The trial of the same of the s	12. Was Decedent Ever in U.S Armed Forces?	5. 13. Y	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (S an, Mexican, Pue	Specify Yes or North Rican, etc.)	0- 1	<ol> <li>Race - Amer Black, White</li> </ol>	
36	I', or	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	t√⊒Yes 2 □ No If Yes, Give 51 - 5 Year or Dates: 51 - 5	5	¹□Yes 2√√ No	Specify:			Specify:	White
Ş	2 hou	ed	15. Decedent's Educ	cation	16a Deced	ient's Usual Occup	pation		16b. Kin	d of Business/l	Industry
212	ad within 72 rgiene. er than "n	pie				kind of work done during most of working DO NOT use retired)			E.I. DuPont/Nylon		
7		Completed	12	Conego (1 401 51)	Mechar	nic Millw	right		E.I	. DuPon	t/Nylon
Maryland 21215-0036	al Hy d oth	Be (	17. Father's Name (First, Middle, Last)					me (First, Middle		Su <i>mam</i> e)	
<u>X</u>	should be find Mental he marked of	2	John Emory Payne				L	Philli			
Jar	C1 40 = 50		19a. Informant's Name/Relationship (Ty)		ì	ng Address (Street					
a)	1 and 1 Health tem 27 other tr		Marie D. Payne/			SUEDA V sition (Name of	ista A	ve., re		ation - City or	g, MD21632
وّ	00		1 TyBurial 2 □ Cremation 3 □ R	CO.	metery, crer	natory or other plac		120106	111		
altimore,	permit. Peg Department Important: i any injury o		4 ☐Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License			y Cemet	ee of Eacility				
Ba	permit. I Departm importar any inju		Muhail 7	. Eskow		deralsbu	Fr	amptom 1632	Fune	eral H	ome, P.A.
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.								Approximate Interval Between
	Physician /Medical						e la la caractería de l				Onset and Death
26			resulting in death)	Due to (or as a consequence of):							yus
	Examiner										
	LAMINICI		Sequentially list conditions.	)							
		iner	Sequentially list conditions, in the cause. Enter Underlying	Due to (or as a conseque	ence of):		-				
		xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		on e						
. 60,		Examin	that initiated events	7.21.00/10/20	on e						
68760,		dicai Examin	that initiated events		on e						
ox 68760,		dicai Examin	resulting in death) Last	Due to (or as a consequent.)  Due to (or as a consequent.)	ence of):				2	3d. Date of deli	ivery
Box 6		dicai Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Due to (or as a consequent.  Due to (or as a consequent.  Solution of pregnant 1 Live birth 2 Fetal 4 Pregnant at time of de	ence of):	]Ectopic pregnancy ] Other (specify)	y		2	3d. Date of deli	ivery Day Year
Box 6		dicai Examin	resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant	Due to (or as a consequent.  Due to (or as a consequent.  J. (1)  J. (1)  J. (2)  J. (2)  J. (3)	ence of):		y		2		,
P.O. Box 6		Physician/Medical Examin	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	Due to (or as a consequent.  3c. If yes, outcome of pregnant   Dicke birth   2   Fetal   4   Pregnant at time of de 9   Unknown	ence of):  ncy death 3 [ ath 5 [	Other (specify)		23e. Did		Month se contribute to	Day Year the cause of death?
P.O. Box 6		by Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	Due to (or as a consequent.  3c. If yes, outcome of pregnant   Dicke birth   2   Fetal   4   Pregnant at time of de 9   Unknown	ence of):  ncy death 3 [ ath 5 [	Other (specify)				Month se contribute to	Day Year the cause of death?
P.O. Box 6	aw requires that the death certificate be executed is been signed by the attending physicien and 2 should be detached for use as the burial-transit	by Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	Due to (or as a consequent.  3c. If yes, outcome of pregnant   Dicke birth   2   Fetal   4   Pregnant at time of de 9   Unknown	ence of):  ncy death 3 [ ath 5 [	Other (specify)		1 🗆 24a. Wa auto	tobacco us	Month  se contribute to  No 3 □ Pro  24b. Were au	Day Year  the cause of death?  obably 4 □Unknown
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P.O. Box 6	or Attanding Physician: The law requires that the death certificate be executed for death.  If death: If a factor: After this certificate has been signed by the attending physicien and not the funeral director, page 2 should be detached for use as the burial-transit.	edical Certification; To Be Completed by Physician/Medical Examin	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	Due to (or as a consequence of	ence of):  ncy death 3 [ ath 5 [  Iting in the u  ER/Outpatier 28b. Time o Injury  me, farm, str )  wledge, deat ion and/or in	other (specify)	26. Place of Denote: 4 Nursing ry at rk?  Yes 2 No	24a. We autopen 1 Yes eath (Check only Home 528d. Describe 28d. Describe 28d. Location City or Total Control of the curred at the time	tobacco use Yes 22 No one) sidence 6 how injury (Street and own, State) a cause(s), date and	Month  se contribute to   No 3 Pro  24b. Were au prior to o death? 1 Yes  Cher (Spectrocourred)  d Number or Ru  and manner as place, and due a signed (Month)	Day Year  the cause of death?  obably 4 □Unknown  toppy findings available completion of cause of 2□ No  cify)  viral Route Number,  stated, to the cause(s)  h. Day, Year)
P.O. Box 6	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours effer death.  To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit	Medical Certification; To Be Completed by Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequent)  3c. If yes, outcome of pregnant 1   Live birth 2   Fetal 4   Pregnant at time of de 9   Unknown  1   Inpatient 2   E   E   E   E   E   E   E   E   E	ence of):  ncy death 3 [ ath 5 [  Iting in the u  ER/Outpatier 28b. Time o Injury  me, farm, str )  wledge, deat ion and/or in	other (specify)	26. Place of Denote: 4 Nursing ry at rk?  Yes 2 No	24a. We autopen 1 Yes eath (Check only Home 528d. Describe 28d. Describe 28d. Location City or Total Control of the curred at the time	tobacco use Yes 22 No one) sidence 6 how injury (Street and own, State) a cause(s), date and	Month  se contribute to   No 3 Pro  24b. Were au prior to o death? 1 Yes  Cher (Spectrocourred)  d Number or Ru  and manner as place, and due a signed (Month)	Day Year  the cause of death?  obably 4 □Unknown  toppy findings available completion of cause of 2□ No  cify)  viral Route Number,  stated, to the cause(s)  h. Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** OCTOBER 2006 2:11 A<sup>M</sup> JOHN SAMUEL PROCTOR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner CHARLES GENESIS ELDERCARE LA PLATA CENTER LA PLATA If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month, Day, Year 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1**X**□M 2□F Yrs. 67 OCTOBER 17, 1939 MARYLÁND 215-36-2758 Director Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. Count 10c. City. Town or Location r than "natural, or iteme 23e or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Directo MARYLAND CHARLES WELCOME 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20693 UNITED STATES ANNAPOLIS WOODS ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: BLACK Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) LUMBER INDUSTRY 10TH GRADE LUMBERJACK other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth eny lipty or other treumatic event 2008. Be JANE A. KEY PROCTOR ROBERT SHERMAN PROCTOR ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7000 BRAGG PLACE / P.O. BOX 355 PORT TOBACCO, MARYLAND 20677 AUGUSTUS A. PROCTOR, SR./BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State THE HUNTT CREMATORY OCTOBER 26, 2006 WALDORF, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. And ture of Funeral Service Monsee THORNION FUNERAL HOME, P.A. LADIA C. THORNIUN JOHNSON MOU583 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CUTE /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence ot): O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☐ No Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 ☐ Yes Division of Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours effer daath.

To the Funeral Director: After this of completely filled in by the funeral directors. 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 \ Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dock Rd, KING GELARCHZ 170 RICHARD Day, Year) 32. Segistrar's Signature 31. Date filed (Month, State

Registrar

		-	1 - For State Registrar	State of Mar	yland / Depa <i>Cei</i>	artment of H	lealth and Me Death		en <b>2</b> 006	35574
	Dhysisi		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month		3. Time of Death
	Physicia /Medic	al .	Annie		Palmer			Month 10	20 2006	T "
	Examin	er	4a. Facility Name (If not institution, give s (Home) 1004 We			*	Location of Death		4c. County of Deal	
	Funeral		5. Social Security Number 6. Sex		In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birl	thplace (State or Foreign
Ь	Director		221-26-9872	M 2XF	65 Yrs.	Months Days	Hours Min.	(Month, Day, 05-02-		ountry)
	pug *		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town or Lo	cation				10d. Inside City Limits
	Maryla f sho	ō								1 Yes 2 ☐ No
	28e-	Director	MD Wicomic  10e. Street and Number	0	Sa.	isbury 101. Zip Code		10	g. Citizen of What Co	ountry?
	23e o		1004 West Roa	d		21801			USA	
	ems ems	Funeral		2. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Specan, Mexican, Puerto R	cify Yes or No- lican, etc.)	14. Race - Ame Black, Whit	
36	s afte	by Ft	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🕱 No	Specify:		Specify: D.1	1-
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. did other than "naturel", or items 23e or 28e-f show event, the Medical Examinar must be redified at	ed b	15. Decedent's Educ		16a. Dece	dent's Usual Occup	ation	1	6b. Kind of Business	ack
215	hin 72 an "ng Medit	plet	(Specify only highest grade	College (1-4or 5+)	life.	kind of work done DO NOT use retired	during most of working	g		
21	e filed within al Hygiene. other than ' vent, tre Me	Completed	12 17. Father's Name (First, Middle, Last)		Bat	ysitter			Daycare	
nd	be file ital Hy od oth	Be	17. Father's Name (First, Middle, Last)  James Ma	nn			18. Mother's Name	<i>(First, Middle, M</i> gie Gib		
Baltimore, Maryland	d 2 should be f th and Mental I 7 is marked ot treumetic ever	2	19a. Informant's Name/Relationship (Ty)		19h Mailir	ng Address (Street	and Number or Rural			Zin Code)
Na	7 5 7 5		Samuel Palmer	(Huch			RD. Sali			
ře,	f H		20a. Method of Disposition		20b. Place of Dispo cemetery, crei	sition (Name of natory or other place	Da	ate 2	0c. Location - City or	Town, State
imo	Pages nent of I ant: If its ury or o		1 Burial 2 □ Cremation 3 □R  4 □ Donation 5 □ Other (Specify)				ter 10-3	80-06 S	now Hill	,MD
Salt	permit. Page Department of Importent: If any Injury or once.		21. Signal se of Fuller ( Service License	98	22	2. Name and Addre	ss of Facility 9	17 W.	Isabella	St.
_	70 E 4 0	Н	23a. Part1. Effer the disease, or compli	actions that coupand th			nith F.H.		, ,	Approximate
			shock, or heart failure. List only or Immediate Cause (Final	e cause on each line.			ig, such as cardiac or	respiratory arre	51,	Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)		consequence of):	reen				2 MONTHS
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	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):					
	ecuter and trans	Examiner	Cause (Disease or Injury) that initiated events resulting in death) Last		consequence of);					
8760,	cate be executed obysician and the burial-transit			. Due to (or as a t	sonsequence on,.					
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	o deatl	Physiclan/M	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregnant at tir		Other (specify)			Month	Day Year
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ds,	signed to	d by	Partil. Other significant contains to	tributing to doubt but	not resolving in the c	indonying oddoo giv	on are are a			robably 4 Dunknown
COL	w requir been si should I	Completed						24a. Was an	24b. Were at	utopsy findings available
Re	The lay	ошо						autopsy perform	ed? death?	completion of cause of
Vital Records,		0	25. Was case referred to medical	500			26. Place of Death			
of V	S S	To B	Tes Z No	lospital: 1 🗌 Inpatient		1. 30 DOX	200		nce 6 Other (Spe	cify)
	ding Ph h. After th funeral	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	Wor	yat 2. k? Yes 2. □No	8d. Describe ho	w injury occurred	
Division	death ctor: y the i	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury	/ - At home, farm, str			8f. Location (Str.	eet and Number or R	ural Route Number,
Σ	after after I Dire	Certification:	4 Homicide determined	building, etc.		,,		City or Town,	State)	
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer			sician: To the best of ner: On the basis of e						
	the h hin 24 the F nplete	Medical	one)	and manner state		29c. Licens			d. Date signed (Moni	
	To To	4	29b. Signature and title of certifier  AsCarr alexander	_ M.	۵ _		7168		0/23/0	
,	10h		30. Name and address of person who co	/						
	50		ROBERT ALLEN	M.D - 13	46 5- DI	V. 57. 3	ALISBURT	MS	21804	
	Sta		31. Date filed (Month, Day, Year) OCT 2 4 20	32. Pagistrar	s Signature		ALISBURT	7		
	Regist	rar	001.44.4	JUD Latery	U 15 1	0348				

			_ For	State of Maryland / D		· ·	giene.	0 7 -
			1 - Stata Registrar		Certificate of L		Reg. No. 2006	35575
П	Physici	an	Decedent's Name (First, Middle, Last			2. Date of De Month	Day Year	3. Time of Death
	/Medic		Jenny Beth Powers  4a. Facility Name (If not institution, give		4b City Town or	Location of Death	r 20, 2006 4c. County of Dea	4:30 PM
1	Examir	ier	411 West Potomac		Brunswic		Frederic	
	Funeral		Social Security Number     6. S		Months Davs	Hours Min. 8. Date of Bir (Month, Date of May 24	th 9. Bir	thptace (State or Foreign
	Director		Usual Residence of Decedent	□ M 2188 F 32	Yrs.	May 24	, 19/4 Vir	ginia
	yland #		10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits
	e-f sh	tor	Maryland Freder	ick Brunswi	ick			1⊠Yes 2□No
	ith the	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Co	ountry?
	23a	rai	411 West Potomac		2171		United	
	item item	Funerai	11. Marital Status  1 □ Never Married 2X Married	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No	If Yes, specify Cuba	ispanic Origin? (Specify Yes or No in, Mexican, Puerto Rican, etc.)	14. Race - Ame Black, Whit	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or iteme 23e or 28e-f show any folury or other traumatic avent, the Medical Exertinar must be resulted at once.	5	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 25X No	Specify:	Specify:	White
5-0	72 ho	Completed	15. Decedent's Ec	lucation 16a.	Decedent's Usual Occupa (Give kind of work done of	during most of working	16b. Kind of Business	/Industry
121	within and the man	idu	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired	)	7	
d 2	Hygie ther ther		12 17. Father's Name (First, Middle, Last)		ental Assist	ant 18. Mother's Name (First, Middle	Dental Co	are
an	ld be lental ked o	To Be	Timothy J. Collin			Lily Painter	, ,	
ary	and Namer	-	19a. Informant's Name/Relationship (	Type, Print) 19b.	. Mailing Address (Street a	and Number or Rural Route Numb	er, City or Town, State, .	Zip Code)
	and 2 ealth n 27 in					St., Brunswick	MD 21716	
Ore	ges 1 if of H or oth		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐	Removal from State cemeter	Disposition (Name of y, crematory or other plac	October 25,	20c. Location - City or	Town, State
Baltimore,	it. Pa		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Little	1 Teaba	nt View Cemet		Jefferson,	
Ba	Depermine Deperm		21. Signature of unital activities Elicen	566	Resthaven	s of Facility Funeral Services	s, Skkot Co	dy P.A.
			23a. Part1. Enter the disease, or compshock, or heart lailure. List only	plications that caused the death. Do n		tin Mtn. Hwv. F g, such as cardiac or respiratory a		Approximate
	Physician	: ()	Immediate Cause (Final disease or condition					Intervat Between Onset and Death
	/Medical		resulting in death)	a. Hanging  Due to (or as a consequence of	of):			Minutes
п	Examiner		Sequentially list conditions,	b				
	led Isit	nine	Sequentially list conditions, large leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	of):			
Ć,	e be executed /sician and e burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequence of	of):			
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.89	death certifical e ettending phy d for use as th	Medi	IF FEMALE:					
Вох	ath ce ttendi or use	lan/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death			23d. Date of de Month	livery Day Year
	at the de by the e tached f	Physician/M	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5 Other (specify)			July 754.
P.O.	that the		Part II. Other significant conditions of	ontributing to death but not resulting in	the underlying cause give	en in Part I. 23e. Did t	obacco use contribute to	o the cause of death?
Records,	w requires that been signed b should be deta	Completed by	Bipolar Affective	Disorder, Depres	sed	1 🗆	Yes 2.131No 3.∏P	robably 4 Unknown
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Division of Vital	Physic this c	2	1 X Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 ER/Out		4   Indiang Home 5 Mares	dence 6 Other (Spe	ocify)
on	ath. r: After e funer	Certification:	1 □Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year) Ir	njury Worl	Yes 212 No hung se	lf with rop	e e
Visi	Attandi er death. rector: A by the fu	tiffica	3 Suicide 6 Could not be 4 Homicide determined	One Diego of Laives At home to			Street and Number or R	
Ö	ital or	Cer		At home				Brunswick,MD
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medicai	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☑ Medical Examone)	ysicien: To the best of my knowledge niner: On the basis of examination and	dor investigation, in my op	ne, date and ptace, and due to the pinion, death occurred at the time,	cause(s) and manner as date and place, and due	s stated. e to the cause(s)
	ithin 2 o the	Med	29b. Signature and title of certifier	and manner stated.	29c. License	e number	29d. Date signed (Mont	th. Dav. Year)
	⊬ ≯ ⊬ 8		1 30. K	Ou MAN	ME D 371		October 23,	
	2		30. Name and address of person who	completed calls of death (Item 23a) (	(Type, Print)			
	9		Alan Rohrer, M.D.		enth St., Fr	ederick, MD 2170	)1	
	Sta		31. Date filed (Month, Day, Year)	32. Prigistrar's Signature	Sound .			

DHMH 17 Rev 1/2001

Registrar

OCT 2 4 2006

			1 - State Registrar	4		of Marylar		artment of rtificate o				Reg. No.	000	355	77
	Physicia		Decedent's Name (First,     WILLIAM GE			, JR.					2. Date of De. Month Octobe	Day	, 2006	3. Time of D	
	/Medic		4a. Facility Name (If not ins		•			4b. City, Town	, or Location o	of Death			County of Deat		
			25211 Foxcha						ertown			Ke			
	Funeral Director		5. Social Security Number 368-36-0894		Sex I⊠M 2□F	7. Age (In yrs.	71 Yrs.	If Under 1 Yes Months Day		Min.	8. Date of Bin	1935	9. Birti	hplace (State or I untry) MI	Foreign
and	* -		Usual Residence of Deced	dent County	-	10c. C	ity, Town or Lo	cation						10d. Inside City	Limits
Mary	-1 ehd	to	MD KI	ENT			CHEST	ERTOWN						1 ☐ Yes 2	2X No
h the	r 28a	rec	10e. Street and Number					10f. Zip Code	9			10g. Citiz	zen of What Co	untry?	
th wi	23a (	aiD	25211 FOX	CHASE	DRIVE			21620				USA			
urs after dec	f Heelth and Mental Hygiene. Item 27 is marked other then "naturel", or iteme 23a or 28a-f ehow other treumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2[ 3 Widowed 4 Di		Armed F	2 🔯 No	1	Was Decedent of If Yes, specify C 1 ☐ Yes 2 📉 N		gin? (Spec n, Puerto F	cify Yes or No Rican, etc.)		14. Race - Ame Black, White Specify: WH	e, etc.	
2 25	dical	eted	15. De (Specify only	ecedent's E	ducation ade completed		16a. Dece	dent's Usual Occ	cupation	t of workin	na	16b. Kir	nd of Business/	ndustry	
ig F	hen a	Completed	Elementary/Secondary (	-		1-4or 5+)	life.	C RELAT	ired)			۸۱۲۳۰	OMOTIVE		
iled A	Hygie ther t		17. Father's Name (First, A	Middle, Last			FUBLI	C KELAI			(First, Middle,				
should be	fental rked o	To Be	WILLIAM G			r, SR.					ERINE M				
and 2 show	tra tre		19a. Intormant's Name/Re PATRICIA					ng Address (Stre 1 FOXCH							
Pedes 1	ant: if		20a. Method of Disposition 1 ☐ Burial 2 🖔 Crem 4 ☐ Donation 5 ☐ O	nation 3			cemetery, crer	sition (Name of matory or other of CE CREMA	TORY		5/2006		cation - City or ENSVILL		
permit.	Depertiment eny in one		21. Signature of Funeral S	iervice Lice	effect	lein	F F F 1 3	Name and Add CLLOWS SO SPEER	HELFEN. ROAD,	BEIN CHES	AND NE	WNAM N, M	FUNERA D 21620	L HOME,	PA
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DIVISION OF VITAL MECONS, F.O. BOX 00/00,	been signed by the attending phys should be detached for use as the	Physician/Med	IF FEMALE:  23b. Was decedent pregn in the past 12 month:  1 ☐ Yes 2 ☐ No 9 ☐ Unknown		1 Live	itcome of pregr birth 2 ☐ Fet nant at time of nown	aldeath 3□	Ectopic pregna Other (specify)				2	23d. Date of deli Month	very Day Ye	ear
ouires thet	en signed b	þ	Part II. Other significant o	conditions	contributing to o	death but not re	sulting in the u	nderlying cause	given in Part I.	•	290 Did t			the cause of dea	
The law re	cate hes ber pege 2 sho	Completed						·				an sy orn ed? 2 No	24b. Were au prior to se death?	topsy findings averaged to the second to the	vailable use of
VICIAN	ector.	Be	25. Was case reterred to re examiner?	medical	Hospital:			1,	26. Place	of Death	Speck only o	one)			
5 £	r this	. To	1 Yes 2 No	-	1 1 1		28b. Time o	IL SEL DOA	4 🗆 140		8d. Describe I		Other (Spec	afy)	
	e fune	atior		Pending investigation		of Injury oth, Day Year)	Injury	V	Vork? ☐ Yes 2 ☐ I	-		,,	,		
DIVIS	within 24 hours after deeth.  To the Funerel Director: After this certificate hes completely filled in by the funeral director, pege 2.	Certification;	3 Suicide 6 4 Homicide	Could not be determined	286. Plac	e ot Injury - At I ling, etc. (Spec	nome, farm, str ify)	eet, factory, office	Ce Ce	2	8t. Location (S City or Tox	Street and wn, State)	d Number or Ru	ral Route Numbe	Θ <i>r</i> ,
he Hospi	n 24 hour he Funer bletely fills	edical	29a. Certifier 1 C (Check only one)	ertifying Pl ledical Exa	miner: On the I	e best ot my kn basis of examin oner stated.	owledge, deat ation and/or in	n occurred at the vestigation, in m	time, date an y opinion, dea	d place, a th occurre	nd due to the ed at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
To	To t	2	29b. Signature and title of	certifie	1				ense number	<b>.</b>			e signed (Monti		
			P /	V	X				0517	86		10	-93-0	16	
			30. Name and address of	Her	COMPILED CAU	HDK	20 S	Print)	RDBK	4B	Che	der	taunt	C0160.	10
	Sta Registr		31. Date filed (Month, Day	r, rear) (	2006	Registrar's Sign	ature			J					
DHMH	17 Rev 1/2		UU	164	2000	Delve	15.	goetes							

		1	For State Registrar	State of Ma	-		rtment of H tificate of L			giene Reg. No.	2006	35579
			Decedent's Name (First, Middle, Last	1)					2. Date of De		Von	3. Time of Death
	Physicia		Doris Patsy H	Rhođes					Octobe	r 18	, Year 200	06 6:45 a <sup>M</sup>
	/Medic Examin	_	4a. Facility Name (If not institution, give	street and number)	-		4b. City, Town, or	Location of Death		4c. (	County of Dea	th
			Hebrew Home of G	reater Was	hington	L	Rockvi			1	Montgon	nery
	Funeral		5. Social Security Number 6. Se	7. Age	(In yrs. last bir		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ay, Year)	C.	rthplace (State or Foreign ountry)
	Director		246-30-6520	_ M 223 F	80	Yrs.			Feb. 1	5, 19	926 No	orth Carolina
	and w	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Lo	cation					10d. Inside City Limits
	Aaryli f aho	0	Maryland Montgor	nerv	Rock	vi1	1e					1 AYes 2 □ No
	28a-	Director	10e. Street and Number	псту	ROCK		10f. Zip Code			10g. Citiz	en of What C	ountry?
	With With		6121 Montrose Roa	ad			20852			¹ Uı	nited S	States
	death me 2:	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.S.	13. V	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (S)	pecify Yes or No		4. Race - Am Black, Whi	erican Indian,
0	or ite		1 Never Married 2 Married	Armed Forces?  1 Yes 2 X	40		Tes, specify Cuba	Specify:	o moan, etc.,		Specify:	118, 810.
2-003p	within 72 hours after death with the Maryland ene. Than "natural", or iteme 28a or 28a-f ahow he Medical Examinar must be notified at	1 by	3 🖾 Widowed 4 🗌 Divorced	Year or Dates:			103 223110	opoury.			Wr	nite
ה ה	72 h	Completed	15. Decedent's Ed (Specify only highest grad	ucation de <i>completed)</i>	16a	. Deced (Give	lent's Usual Occupa kind of work done of DO NOT use retired	ation furing most of wor	king	16b. Kir	nd of Business	s/Industry
Z	nen hen	du l	Elementary/Secondary (0-12)	College (1-4or 5	i+)		countant	)		Δ,	ccounti	ino
N	lled w lygie her t		17. Father's Name (First, Middle, Last)			AC	Countaine	18. Mother's Nan	ne (First, Middle			L116
/land	ntal h	Be	John Cole						la Nunn		·	
_	d Me d Me mark matic	2	19a. Informant's Name/Relationship (7	Type, Print)	198	b. Mailin	ng Address (Street a				Town, State,	Zip Code)
Za	d 2 s th an trau		Michael Rhodes	_			Granby St					
	Heal Heal tem 2	1	20a. Method of Disposition				sition (Name of natory or other plac		Date		cation - City o	
<u></u>	ages ant of it: It i		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify				Mem. Par		4/2006	Wiln	ningtor	n, NC
saitimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural; or items 53s or 28s-f show any injury or other traumatic avant, the Mudical Examinat must be notified at any injury or other traumatic avant, the Mudical Examinat must be notified at any injury or other traumatic avant.		21. Signature of Funeral Service Licen			S 1	Name and Address	ss of Facility	ral and	Cre	nation	Center
	403 e d		23a. Part1. Enter the disease, or com	- / Wolf	I the death Do						, Maryl	Approximate
			shock, or heart failure. List only	one cause on each li	ne.			3,	,			Onset and Death
*	Physician /Medical		disease or condition resulting in death)	9			leukemia					l year
	Examiner	l	1	Due to (or as	a consequence	01):						
%		ē	Sequentially list conditions, if any, leading to immediate	b. Due to for as	a our sequence	ch:						
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C								
'n	exec an an rial-tr	Exa	resulting in death) Last	Due to (or as	a consequence	of):						
8760	cate be executed physician and the burial-transit	dlcal	(	d						_		
9	ntifica ng ph		IF FEMALE:									·
Box	death certifi e attending   id for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal deat		Ectopic pregnancy	,		2	23d. Date of de Month	elivery Day Year
0	the dea y the al	slcl	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4 Pregnant a	t time of death	5 L	Other (specify)					
1	that the de ted by the a detached t		Part II. Dther significant conditions of	ontributing to death b	out not resulting	in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco u	se contribute	to the cause of death?
Records,	8 5 6	d by							1□	Yes 2	<b>X</b> No 3 □ F	Probably 4 Unknown
Ö	w require been sign should t	Completed							24a. Wa	s an	24b. Were a	autopsy findings available
Ä	has law	E D							auto	opsy formed?	prior to death?	completion of cause of
B		ပိ	25. Was case referred to medical					26. Place of De	1 Yes		1 🗆 Ye	es 2 No
5	Physician: rthis certificanal director, i	o Be	examiner?	Hospital:	ent 2 🗆 ER/O	Outpatier	nt 3 DOA Oth	or.	Home 5 Res		6 Dother (Sp	ecify)
ō	g Phy ter this neral c	-	27. Manner of Death	28a. Date of Inju (Month, Da		Time o		y at	28d. Describe	how injur	y occurred	
<u></u>	Attending ir death. actor: After by the fune	atio	1 ØNatural 5 ☐ Pending 2 ☐ Accident investigation		ly 16ai)	injury		Yes 2 □No				
Division of Vital	or Attendated death Director:	Certification:	3 Suicide 6 Could not b 4 Homicide determined	280. Place of in	jury - At home, t tc. <i>(Specify)</i>	farm, st	reet, factory, office	* .		(Street an own, State		Pural Route Number,
	Hospital 4 hours Funeral ely filled	edical Ce	29a. Certifier 1 🔀 Certifying Pt (Check only one)	nysician: To the best niner: On the basis of	of examination a	ge, deat	th occurred at the tire	me, date and place pinion, death occ	e, and due to the urred at the time	e cause(s) e, date and	and manner place, and de	as stated. ue to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner st	/7	-	29c. Licens	e number		29d. Dat	te signed (Moi	nth, Day, Year)
1	F 3 F 8		Han Doe.	v Kles	nder	141	D03	6716		10	/18/06	
			30. Name and address of person who	completed cause of	death (Item 23a	) (Type.						
			Andrew Kundrat,	M.D. 612	1 Montr		Road; Ro	ckville.	Maryla	nd 20	0852	
		ate	31. Date filed (Month, Day, Year)	32 Pagist	rade Signatura							
	Regist	rar	OCT 2 5 20	UD SOLVE	, H	1400	MEL .					

			For State Registrar	State of	Maryland		rtment of H			ene g. Nd.	06	35580
1	Physicia	₩ In	1. Decedent's Name (First, Middle, La						2. Date of Death Month	Day	Year	3. Time of Death
	/Medic	al .	Mae Roberta Ra  4a. Facility Name (If not institution, gir				4h City Town or	Location of Death	October	T	006 ty of Death	9:43 P. <sup>M</sup>
	Examin	er	Calvert County Nu				*	Frederic	k	Calv	•	
	Funeral Director		5. Social Security Number 6. 213–46–9749		7. Age (In yrs. I. <b>96</b>	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 5,		9. Birthp Cour Mary	
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation				1	0d. Inside City Limits
	Mary -f sho	tor	Maryland Calvert		Hunt	tingto	wn					1 ☐ Yes 2 X No
	or 28e	lrec	10e. Street and Number				10f. Zip Code		10	g. Citizen o	f What Cour	itry?
	ath wi	ral	1895 Solomons Isl				20639				Stat	
9	or items	by Funeral Directo	11. Marital Status  1 Never Married 2 Married	Armed For 1 Tes If Yes, Giv	2 <b>X</b> No e	l I	Was Decedent of H f Yes, specify Cuba 1 □ Yes 🌠 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	Rican, etc.)		ack, White,	etc.
5-0036	hours tural;	q pe	3  Widowed 4 □ Divorced  15. Decedent's E	Year or Da	ates:	16a Decec	ient's Usual Decup	ation		6b. Kind of	Whi Business/In	
21215	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Madical Examinar motal be inclined at	Completed	(Specify only highest gi		-4or 5+)	(Give	kind of work done o DO NOT use retired	during most of work			emaker	
<u>0</u>		0	17. Father's Name (First, Middle, Las	t)		nouse	WIIC	18. Mother's Nam	e (First, Middle, N			
<u>Ilan</u>	should be nd Mental I marked o	To B	Walter Buckmaster	:				Ida L.	Hardesty			
Maryland	and and sum		19a. Informant's Name/Relationship				ng Address (Street					
	1 and 2 Health Sm 27 ther tra		Mary Esther Cox (	(Daughte:			Solomons sition (Name of				OWIN , M n - City or To	
D	Pages nent of I int: if its		N□ Burial 2 □ Cremation 3   4 □ Donation 5 □ Other (Spec		State	emetery, crer	natory`or other plac					c, Maryland
Baltimore,	permit. Page Department of Important: if any injury or once.		21. Signature of Funeral Service Lice	-	CIII.	22	Name and Address 205 Broomes	ss of Facility R	ausch Fu	neral	Home,	P.A.
4	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only limited and limite	a	aused the death ach line.  or as a consequence or a	uence of):	4 1 .	g, such as cardiac	-			Approximate Interval Between Onset and Death
8760,	icate be ex physician s the buria	dlcal	•	d							-	
.O. Box 6	death certif e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1 ☐ Live b	come of pregna wirth 2 Fetal ant at time of do	death 3	Ectopic pregnancy				Date of delive Month	ery Day Year
<b>Q</b>	uires that the signed by Id be detacted	by	Part II. Other significant conditions	contributing to de	eath but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tob			ne cause of death?
Il Records,	Physicien: The law requires that the this certificate has been signed by the director, page 2 should be detached.	Completed							24a. Was an autops perform	/	o. Were auto prior to co death? 1  Yes	psy findings available mpletion of cause of
Vital	ilcien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth		th Check only on	7		
ot	rng l fter iner	tlon; To	1  Yes 2 No  27. Manner of Death  Natural 5  Pending 2  Accident investigate	28a. Date (Mon.		ER/Outpatier 28b. Time o Injury	f 28c. Injur Wor	er: Nursing H y at k? Yes 2 □No	ome 5 Reside			ý)
Division	l or Attend after death Director: /	Certification:	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place	of Injury - At ho ing, etc. (Specif		reet, factory, office		28f. Location (St. City or Town		mber or Rura	al Route Number,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	edical C		aminer: On the b			h occurred at the till vestigation, in my o					
	To th within To th сощрі	Me	29b. Signature and title of certifier	1 1	1		29c. Licens		2	•	ned (Month,	
			<b>\</b>	1/10			D3	3123		10	26-0	6
	3		30. Name and address of person wh					210 5	does To	ا- لحجولة	. 100	20679
10	Sta	10	Jonathan Lowenth 31. Date filed (Month, Day, Year)	20 5	O'	4			ince Fre	ueric	لللالا رك	20070
	Regist		ncT	2 6 2006	Heneu	ar St.	Sparke	p				

			For State Registrar	State of M	Maryland / De	oartment e <i>rtificate</i>			and Mental	Hygiei Reg.	Z U	06	355	81
A			1. Decedent's Name (First, Middle, Last)			···			2. Date of Month		Day	Year	3. Time of	Death
	Physicia /Medic	_	Evelyn Repp						Oct	ober	21,	2006	7:38	рМ
	Examin		4a. Facility Name (If not institution, give s					Location o	f Death		4c. Coun	ity of Death		
Silv	- A		Washington Adventis			Takon		ark If Under 2	24 Hrs. 8. Date of		lontg	omery	place (State o	- Foreign
	Funeral Director			M 2X)F	Age (In yrs. last birthda 96 Yrs.	Months	Days	Hours		ı. Dav. Ye	ar) 1910	Cou	ntry) fornia	
	ig.		Usual Residence of Decedent						Tiar Ci	,	1710	10011	TOTHE	
	how		10a. State 10b. County		10c. City, Town or	Location							10d. Inside Ci	
	e Ma 3e-1	cto	Maryland Prince Geo	orge's	Hyattsvi	11e							1 🗌 Yes	2XIN0
	with th	Dire	10e. Street and Number			10f. Zip						f What Cou	ntry?	
	s 23a	ra	3916 Calverton Driv	7e 12. Was Decede	at Finar in II C 1	2078		nania Osia	-in? (Capaity Vac	U.S	1	ace - Ameri	can Indian	
	ter de	Funeral Director	11. Marital Status  1 Never Married 2 Married	Armed Force	s?	If Yes, speci	fy Cubar	n, Mexican	gin? (Specify Yes o , Puerto Rican, etc	.)		lack, White,		
920	al', or	by	3	If Yes, Give Year or Date	-	1 ☐ Yes 2	X No	Specify:			Spec	whi	te	
21215-0036	72 hours after deeth with the Maryland natural; or Items 23s or 28e-f ehow dical Exantinational be notified at	Completed	15. Decedent's Educ (Specify only highest grade		16a. De	edent's Usual	Occupa k done di	tion u <i>ring most</i>	of working	16b	. Kind of	Business/ir	dustry	
7	within ene. then	mple	Elementary/Secondary (0-12)	College (1-4d	or 5+)	. DO NOT use	e retired)							
7	e filed v al Hygie other t vent, IL		17. Father's Name (First, Middle, Last)	2	Home	naker		18 Mothe	r's Name (First, Mi		n Ho			
Maryland	d be find he of other	Be	Arnold Madsen						ude Olsei		2011 501111	amoj		
7	2 should be and Mental is marked or raumatic even	P.	19a. Informant's Name/Relationship (Ty)	oe, Print)	19b. Ma	iling Address			or or Rural Route N		ty or Tow	n, State, Zij	o Code)	
Ma	nd 2 still ar 27 is r trau		Elaine Murphy - Dau	i hter	ì				ve, Hyati					
re,	iges 1 and 2 should be filed within 72 hours atter deeth with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28e-f show or other traumatic event, the Medical Exant		20a. Method of Disposition		20b. Place of Dis				Date	_		n - City or T		
Ē	Pages nent of I nnt: If its ury or o		1 ☐ Burial 2 【 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoyal from Sta	10				10/24/20	06 A1	Lexar	ndria,	Virgi	nia
Baltimore,	permit. Page Department of Importent: if any injury or once.		21. Sign rture of Funeral Se - 1 dens	4		22. Name and	d Addres	s of Facilit	Gasch's	Fune	ra1	Home,	P.A.	
	201 2 3		towit !	lay					Avenue,		tsvi	11e,		
7.00 7.00			23a./Parl 1. Enter the disease, or compli- shock, or heart failure. List only or	e cause on each	n line.			, such as	cardiac or respirate	ry arrest,			Approximate Interval Bet Onset and I	ween
	Physician		Immediate Cause (Final disease) or condition resulting in death)	HEN	onto seco	WOTES								
8	/Medical Examiner		1	Due to (or	as a consequence of):	ZA	Lno	13 800						
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequence of):		1100	. 00						
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	CANA	THE MERS	E)								
o,	en an irial-tr	Еха	resulting in death) Last	Due to (or	as a consequence of):	1		_						
8760,	death certificate be executed e attending physicien and attending physicien and ad for use as the burial-transit	edical		11231	VERMINS	13750	756							
9	e as t	Med	IF FEMALE:											-
Вох	eath certific attending pi for use as f	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth		B Ectopic pre						Date of deliv Month	,	Year
P.O.	the de	ysic	1 Yes 2 No	4 ☐ Pregnan 9 ☐ Unknow		5 ☐ Other (spe	эспу)							
	that the de led by the a detached		Part II. Other significant conditions con	tributing to deat	h but not resulting in the	underlying ca	use give	n in Part I.	23e.	Did tobacc	co use co	ntribute lo t	he cause of d	leath?
Vital Records,	law requires as been sign 2 should be	d by								1 🗌 Yes	2/2/No	3 🗌 Pro	bably 4 🗆	Jnknown
CO	law requir as been si 2 should l	olete								Vasan	245	. Were auto	opsy findings	available
Ä	0 - 0	Comple							1 D Y	autopsy performed es 2 🚅		death?	ompletion of c 2□ No	ause or
ital	icien: Th certificate ector, pag	Bec	25. Was case referred to medical examiner2					26. Place	of Death Check					
<u>&gt;</u>	is d	10	1 ☐ Yes 2 ☐ No	lospital: 1 🗌 Inp.			A Othe	r: 4 □ Nu	rsing Home 5	Residence	6 □0	ther (Speci	fy)	
n		on:	27. Manner of Death  1. ☐ Natural 5 ☐ Pending	28a. Date of J (Month,	njury 28b. Time Da <i>y Year)</i> Injur	1	3c. Injury Work	?	28d. Desc	ribe how in	njury occ	urred		
isic	ten leat lor: the	cat	2 Accident investigation 3 Suicide 6 Could not be	280 Place of	Injury - At home, farm,	M street factors		′es 2 🗆 I		on (Street	t and Nur	nhar or Pur	al Route Num	har
Division of	l or Atten after deat Director: I in by the	Certification:	4 Homicide determined	building,	etc. (Specify)	street, lactory,	, omo <del>a</del>			r Town, Si		11001 01 1101	ar rioble right	D81,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier 12 Certifying Phys	sician: To the be	est of my knowledge, de	ath occurred a	at the tim	e, date an	d place, and due to	the cause	e(s) and r	manner as s	stated.	
	n 24 h	edical	(Check only 2 Medical Examinations)	ner: On the basi and manner	s of examination and/or	investigation,	in my op	inion, dea	th occurred at the t	me, date	and place	e, and due t	o the cause(s	)
	To the vithin 2 To the complet	Ž	29b. Signature and title of certifier	GV.	7	29c.	License	number		29d.	1	ned (Month,	Day, Year)	
			Muce	en			20.	3 70	614	10	1/21	106		
R	(8)		30. Name and address of person who co			e, Print)							- 0	2.5.5
1	[0]		Don Michael Colema: 31. Date filed (Month, Day, Year)	22 Dog	1300 Picc		ive	#202,	Rockvil	Le, M	lary1	and 2	0850-4	303
	Sta Registi		OCT 2 5 2006	Enel	Strair's Signature	de								

			for Stete Registrar	State of Marylan		artment o			jiene 0	06	355	82
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day	Year	3. Time of Do	eath
	/Medic	al	Elmo Reddick  4a. Facility Name (If not institution, give s	street and number)		4b. City. Tow	n, or Location of De	Octobe:	r 22	2006 of Death	2115	- M
	Examin	er	Southern Mary1				Clinto				George's	s
	Funeral		Social Security Number     6. Sex	7. Age (In yrs. I		If Under 1 Ye Months Da		lin. (Month. Day	Year)		lace (State or F try)	
	Director		198-09-6290	M 2□F 93	Yrs.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	May 18,	1913	Nort	h Caro	lina
	land		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				1	0d. Inside City	Limits
	Mary find	ţ	Maryland Prince Ge	orge ts		,	remple Hi	11s			1 <b>∑</b> Yes 2	2 □ No
	h the	Director	10e. Street and Number	Jorge o		10f. Zip Coo			0g. Citizen of	What Coun	try?	
	23a c	ie D	4210 Leisure Dr	rive			20748	3	Uni	ted S	tates	
	temes temes	nue		<ol><li>Was Decedent Ever in U. Armed Forces?</li></ol>		Was Decedent f Yes, specify (	of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)		ce - Americ ck, White,		
36	rs aft	by Funeral	1 Never Married 2 Married 3 ¥Widowed 4 Divorced	1 ⊡Yes 2 XNo If Yes, Give Year or Dates:		1□Yes 2🏋	No Specify:		Specif	y:	B1ack	
Š	within 72 hours after death with the Maryland ene. than 'naturel', or iteme 23e or 28e-f ehow he Madical Exandian cual be notified at	ted	15. Decedent's Educ	cation	16a. Dece	dent's Usual Oc	cupation		16b. Kind of B	usiness/Inc	lustry	
215	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use re	one during most of tired)	working	_		chool ernment	+
2	led wi		6th			Main	tenance					
and	ntal H od ott	Be	17. Father's Name (First, Middle, Last) Hugh Red	ldick			18. Mothers I	Name (First, Middle,	<sub>Maiden Sumar</sub> e (Unkn			
Maryland 21215-0036	Should nd Me mark mark	၉	19a. Informant's Name/Relationship (Ty)		19b. Maili	ng Address (Sti	reet and Number or	Rural Route Number			Code)	
Ž	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or iteme 23e or 28e-f ehow any injury or other treumatic event, the Madical Examinet must be notified at ance.		Jacquelyn Whitfiel	Ld/Granddaught				, Temple 1	0.000			
Baltimore,	of He of He rother		20a. Method of Disposition 1	20b. P	lace of Dispo	sition (Name o	1	Date	20c. Location			
Ĕ	Pag ment ent: l		4 Donation 5 Other (Specify)		urrect	ion Ce	netery 10	/26/2006	C1i	nton,	MD	
Ball	Depertit.		21. Signat re of Funeral Service License		22		ddress of Facility	Stewart 1				
	40340	-	23a. Part1. Epter the disease, or compli	ications that caused the death	Do not en			g Rd., NE		, DC	20019 Approximate	
	Dharisina		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.					001,		Interval Betwe Onset and De	
	Physician /Medical		disease or doridition resulting in death)	Due to (or as a consequence)		min	QCC, 1-	PNF				
	Examiner		Sequentially list conditions,									
	sit ad	iner	rany, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uanes of).							
	and and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence)	uence of):					-		
8760,	icate be executed physicien and s the buriat-transit			4								
687	tificate ng phys as the	by Physician/Medical										
Box	death certific e attending p id for use as	M/W	230. was decedent pregnant	3c. If yes, outcome of pregna 1□Live birth 2□Feta		Bectopic pregn	ancy		23d. Da	ite of delive	ry	
	e deat he att	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of di		Other (specif)			Mo	onth	Day Ye	ar
P.O.	that the de ned by the a detached t	Phy	9 ☐ Unknown  Part II. Other significant conditions cor	ntribution to death but not res	ulting in the u	ndarhina causi	a green in Part I	23a Did to	bacco use con	tributa to th	a cause of dea	ath?
ds,	8 5 8		Taxii. Othor significant contactors (Si	imbuling to abatir but not res	aning in the c	nderlying cause	giveri in Fait i.		_		abiy 4 ∐Uni	
COL	> 4	Completed						24a. Was a	24h	Were auto	psy findings av	/ailahle
Re	The law ate hes b page 2 sl	шo						autops perfor	sy med?	prior to cor death?	npletion of cau	ise of
ital	(0	0	25. Was case referred to medical				26. Place of I	1 ☐ Yes  Death (Check only or		1 ☐ Yes	2 No	
<u>&gt;</u>	S .5 5	ToB	examiner? 1 ☐ Yes 2 🕒 No		ER/Outpatie	nt 3 DOA	Other: 4 Nursin	g Home 5 ☐ Resid	ence 6 Oth	ner (Specif)	()	
n c	ding Ph h. After th funeral		27. Manner of Death 1 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		njury at Work?	28d. Describe h	ow injury occur	rred		
Division of Vital Records,	or Attending after death. Director: After in by the fune	licat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	ome farm et		1 ☐ Yes 2 ☐ No	28f. Location (S	treet and Numi	her or Rura	I Poute Numbe	9/
ò	p affig ∈	Certification;	4 Homicide determined	building, etc. (Specif	y)	est, factory, on		City or Tow	n, State)	007 07 71010	7710dib 74dilibe	37,
	Hospital 24 hours a Funeral I	Saic	29a. Certifier 1 Certifying Phys	sicien: To the best of my kno	wledge, deat	h occurred at th	ne time, date and pl	ace, and due to the c	ause(s) and m	anner as st	ated.	
	To the Hos within 24 h To the Fur completely	fedical	one)	ner: On the basis of examina and manner stated.	tion and/or in							
	Tot	Σ	29b. Signature and title of certifier	h. / L			cense number	1	29d. Date signe			
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	9		30. Name and address of person who co	1 2000	701 Li	Vincet.	Rond	, Fut was	Hinten	MA	1 mid	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	die.	-			, , , ,	· · · · · ·	
	Regist	rar	OCT 2 5 2006	Barrell M.	Does							

State of Maryland / Department of Health and Mental Hygiene Reg. No.Z Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 2006 JOHN STEPHEN 12:22 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 (**X**M 2 □ F 185-34-4590 Yrs. Director 1944 New York Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits in than "naturel", or iteme 23a or 28a-f ehow the Madical Examiner must be notified at 1 ☐ Yes 2 📆 🗙 Vo Mt. Airy Director Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? e filed within 72 hours after death with tal Hygiene.
other then "naturel", or iteme 23s or 2 21771 United States 5323 Pommel Drive by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Kitchen Designer Home Depot 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Peges 1 and 2 should be inent of Heelth and Mental Int: If item 27 is marked o John S. Ruby Mary Holkovic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5323 Pommel Drive Mt. Airy, MD 21771 Wife Mrs. Carmen Ruby 20b. Place of Disposition (Name of 20a, Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Pege Department o important: If eny injury or once. South Carroll Crematory Oct. 24, 2006 Winfield, MD 4 □ Donation 5 □ Other (Specify) <sup>22.</sup> Name and Address of Facility Burrier-Queen Funeral Home & Crematory, 1212 W. Old Liberty Road Winfield, MD 21. Signature of Funeral Service Acenses PA 21784 27a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shark, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mandiate Cause (Final disease or condition resulting in death) **Physician** NON SMALL 2 MONTHS CELL LUNG CARGINDMA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atter in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of this certificete has 1 Ves 2 □ No 1 Nes 2 No funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Hospitel or Attending Pl
 A hours effer death.
 Funerel Director: After ti Certification: 28d. Describe how injury occurred 5 Pending 1- Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours of To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOO 56314 WIL OCTOBER 23, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 THOMAS JUHNSON DRIVE, PREDERICK MD 21702 BINDU 46B 600265 MD. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU 6 1 - For State Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** AGNES MAE RIDGLEY OCTOBER 20 2006 7:37 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 700 LAFAYETTE STREET HAVRE DE GRACE HARFORD 8. Date of Birth (Month, Day, Year FEB 10, 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Month s Days 1□M 2√2F MARYLAND 213-28-9200 73 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County other than "netural", or items 23a or 28a-f show vent, the Medical Examinar invest to notified at 1 √ Yes 2 □ No HAVRE DE GRACE MARYLAND HARFORD Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21078 700 LAFAYETTE STREET USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No tf Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: BLACK 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) NURSING ASSISTANT VA HOSPITAL 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be CORNELIUS JONES MARGUERITE STEWART ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) . Health 410 TIDEWATER DRIVE, HAVRE DE GRACE, MARYLAND 21078 LINDA WALTON / DAUGHTER permit. Pages 1 and Department of Health Important: If item 27 eny injury or other 1 0000. Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State UNION UNITED METH CEM 10/24/06 ABERDEEN, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility LISA SCOTT FUNERAL HOME, P.A. 552 LEWIS STREET, HAVRE DE GRACE, MD 21078 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final ABOOMINAL 1998 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Replace ment VAIVE with ANTICOAGULATION 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No ne RoscleRosi 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

physicien and s the burial-transit The law requires that the death certificate be executed Records, P.O. Box 68760 ģ certificate of Vital To the Funeral Director: After this certific completely filled in by the funeral director, Division Attending death. ō within 24 hours a To the Funeral L

ES

death

72 hours after

Mental

Baltimore, Maryland 21215-003

28t. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. D40922

🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 10/20/06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

UNION Ave HANGE de GRACE, MO 21078 407 South WACHSMAN 31. Date filed (Month, Day, Year)

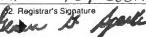
State Registrar

Medical

29a. Certifier

29b. Signatur and title of certifier

OCT 2 4 2006



State of Maryland / Department of Health and Mental Hygiene 35585 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Redinaton 17:05 PM cotober 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore
If Under 1 Year | II Under Hopkins Hospita
6. Sex 7. Age (in yts. last birth) J. Date of Birth (Month, Day, Year) July 21, 1942 Birthplace (State or Foreign Country) 5. Social Security Number s. last birthday) **Funeral** 64 Months Days Hours 1 □ M 2 🔀 F Yrs. 552-58-0967 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County 27 is marked other than "natural", or Items 23a or 28e-f ehow traumatic event, the Medical Examinar must be notified at FL Palm Beach 1 ☐ Yes 2 🔀 No Boca Raton Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4301 North Ocean Blvd. 33431 USA by Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: Vietnam 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian within 72 hours after 1 Never Married 2X Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I Pages 1 and 2 should be Louise M. Bellman Harley M. Shaffer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33431 19a. Informant's Name/Relationship (Type, Print) 4301 North Ocean Blvd, Unit A905, Boca Raton, FL item 27 I Joseph J. Redington/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Oct. 28, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Boca Raton Cemetery Boca Raton, FL 2006 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Hor
495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of Funeral Service du 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Hypoxia /Medical to (or as a consequence of): 10 years Examiner Small Cell Lung Concer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine physicien and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): .O. Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Nnknown Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an certificate has blirector, page 2 s autopsy performe 2 🗆 No 2 1 Yes 1 Tyes of Vital Attending Physician: director, Be 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 1 Inpatient 2 No 2 ER/Outpatient 3 DOA this After thi funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 1) Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: A 2 Accident 6 Could not be 3 Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, larm, street, factory, office building, etc. (Specify) within 24 hours after d To the Funeral Direct completely filled in by filled in by 4 T Homicide To the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) MD 0064525 Tangons Co 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street IANGING 600 31. Date filed (Month, Day, Year) 32. egistrar's Signature State OCT 2 3 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day October 18, 2006 **Physician** 1:26 p.M George L. Rives /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Worcester 745 Laurel Avenue Ocean City | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | O1/10/1940 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**☑** M 2□ F 66 Director 538-34-7579 MI Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyghene. Important: if item 27 is marked other then "natural", or items 23s or 28s-f show any injury or other traumatic event, it a Medical Examiner raist be notified at once. Director Worcester Ocean City 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 745 Laurel Avenue 21842 USA by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Year or Dates: 1958 White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 1962 Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Appliance Distributor 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unavailable Unavailable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 745 Laurel Avenue, Ocean City, MD Judith Rives/Wife 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) Oct. 27, 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Bernoval from State Veterans Cemetery 4 Donation 9 Other (Specify) Crownsville, MD 2006 21. Signature of Funeral Several census 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 3a. ani. Enter the disease of plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List on one cause on each line. Approximate Interval Between Onset and Death immediate Ca u e (Final disease or condition resulting in leath) Carcinona et Bladder Physician 4 400.08 /Medical Due to (or as a consequence of) Examiner equentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate has Be funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Alvatural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the within 24 hours after deal To the Funaral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 12—Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day, Year) 030690 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gr.1151. Fulizbury, MD. 2180, 11/4 RT/N Jones E. M.D. 145 E. 32. Registar's Signature 31. Date filed (Month, Day, Year) State 2006 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death RADCLIFFE **Physician** ARK 86 0241 M 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 03/31/1953 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 6. Sex 12 M 2 ☐ F '. Age (In yrs. last birthday) **Funeral** 53 Director 068-46-7659 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 301 Cadle Avenue 21037 United States Funeral . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 ☐ Never Married 2 📆 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🕱 No Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Certified Orthodist Prosthetist Nascott Rehabilitation permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygis Important: If Item 27 is marked other any injury or other traumatic event, it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick Radcliffe Anne Jaworski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jeanne Radcliffe/Wife 301 Cadle Avenue, Edgewater, Maryland 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Pages 1 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Kalas Crematory 10/21/2006 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fund al Service Licensee <sup>22. Name and Address of Facility</sup> George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 Ulle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Vasopharyn /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to infraedate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 1 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of s certificate has b irector, page 2 sl 24a. Was an autopsy performed? 1□ Yes 2 No death? 1 ☐ Yes 2 □ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 Tyes 2 Accident 24 hours after death e Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier

State Registrar (Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year) OCT 2 0 2008

Name and address of person who completed cause of death (Item 23a) (Type

NTA M

and manner stated.

FENSE HIGHWAY ANNADUS MONYO

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month EOWARD ROCHESTER 18 2006 40415 BCTOBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HESTER RIVER HOSPITAL CENTER KEN7 OWN If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
Mall land Sex 1 MM 2□F **Funeral** Months Hours 79 Days 220-32-9001 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28e-f ahow the Medical Examiner must be notified at 1 Yes 2 No Be Completed by Funeral Director Jucen 10f. Zip Code 10g. Citizen of What Country? 11.SA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Itema 11. Marital Status Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Back Specify f Yes, Give Year or Dates: 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Machine Of injury or other traumatic avant, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any light of other traumatic avant page. 17. Father's Name (First, Middle, Las 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, P.D. Bok 5. GRONS DOLL Kachester 20b. Place of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner METAS STATIOS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Hospitel or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 morths? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ ar GIN COM 1 ☐ Yes 2 No 3 Probably 4 DUnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient Certification: To 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28c. Injury at Work? After t 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funerel Dire 1 Certifying Physician: To the bast of my knowledge, death occurred at the time date and place, and due to the trace(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) ŧ, 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) OCT 2 3 2006 32. Regis State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day RODGERS Lovember 03 0039 M sort. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Hospital of Balt more BAltiMORE Dinai If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 5, 1921 7, Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex Days Hours 1□M 2XF Virginia 220-32-3310 85 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a. State 1 ☐ Yes 2X No MD Baltimore Monkton 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21111 1139 Monkton Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Yes 2 🔼 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 No White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ida Adams William M. Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Herman H. Kupisch, Jr/Son 1139 Monkton Rd., Monkton, MD 21111 Date 6, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Nov. 1 Burial 2 □ Cremation 3 □ Removal from State Wiseburg Cemetery White Hall, MD 2006 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 21. Signature of Funeral Service Licenses E/ % Marke 24 Second St., New Freedom, PA 17349 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lntra Due to (or as a consequence of): Sequentially list conditions, Due to for as a consequence of it any leading to it moute cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last OFFILE VALUE ADODOLUMED EN WELL Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Vear 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 → Thinknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day ) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Natural 2 ☐ Accident fall 10-26-% 1 Tyes 2 No

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

la or 28a-f show t be notified at

or items 23a

other traumatic event, the Medical Examiner must

s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 Is marked other than "natural", or ite

permit. Pages 1 Department of H Important: If it any injury or o

Baltimore, Maryland 21215-0036

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Funeral

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Completed

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certificate be executed attending physician and for use as the burial-transit detached the ģ

Box 68760.

P.O.

Division or Vital Records,

peen has certificate Attending Physician:

Physician/Medical ģ Completed Be P Certification:

Examine

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

25.	Was cas	se referre	d to	medica

27. Manner of Death

3 ☐ Suicide 4 ☐ Homicide

29a. Certifier

5 ☐ Pending investigation 6 ☐ Could not be determined

0 goes

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number Oily or Town, State)

1139 MONTON Rd MO 21111 Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mariner stated.

29b. Signature and the of certifier

29c. License number B06472182 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (flem 23a) (Type, Print) Sinai

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

Medical

State of Maryland / Department of Health and Mental Hygiene [] [] [5

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For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Winslow D. Shaw October 21, 2006 1:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Spa Creek-Genesis Elder Care Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 27, 1917 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) New York **Funeral** Yrs. Director 139-16-9959 88 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits il Hygiene. . other than "naturel", or flems 23e or 28e-f show vent, tre Medical Executival transit be notified at Director MXYes 2 ☐ No Marvland Anne Arundel Annapolis 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 345 Dewey Drive 21401 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No It Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1941-1 ☐ Yes 2 ☐ No Specify: White ģ 3 Widowed 4 Divorced 1946 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) 5+ Minister Presbyterian Church 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental h Pages 1 and 2 should be Charles F. Shaw Eloise Russell ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is eny injury or other trai once. Loraine Shaw / Spouse 345 Dewey Drive, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 10/24/06 Baltimore, Maryland 21 Signature of Funeral Service 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final disease or condition resulting in death) **Physician** M /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine attending physician and for use as the burial-transit to the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been si 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has b 24a. Was an autopsy performed? res 2 No 1 Yes To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; 1 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: , completely filled in by the f 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 50 impleted cause of death (Item 23a) (Type, Print) 13 31. Date filed (Month Day Registrar's Signature State 4 2006

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Registrar

State of Maryland / Department of Health and Mental Hygiene 0 0 6 35591 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 19 2006 Physician 08/8 Jeffrey David Stadvec /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Annapolis Edgewood 7310 KoAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth 11/03/1977 5. Social Security Number 9. Birthplace (State or Foreign 6 Sax 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min New Jersey 1**X**M 2□ F 28 Yrs 138-80-1508 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10h Counts 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No Director Burlington Florence Twp., Roebling 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code ŏ 108 Fifth Ave 08554 U.S.A. Itame 23a Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXIo If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) Black, White, etc. filed within 72 hours after 1XXIever Married 2 Married Baltimore, Maryland 21215-0036 ò 1 Yes 2000 Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12 Driver Rental 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if Item 27 is marked oth any lighty or other traumatic event 9DEs. Be John Stadvec Jr. Barbara A. Csik 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Stadvec Jr. (Father) 300 Whittaker St., AptC9, Riverside, NJ 08075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State Delaware Valley Crem. 10/24/2006 | Southampton, PA 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Hardesty Funeral Home P.A. 0 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Due to (or as a consequence of): Immediate Cause (Final As **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dualto (or as a consequence of) Examiner use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last nding physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ed by the atten-3 □Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has this certificate 1 ☐ Yes 2 No After this certification, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Le Yes 2 No 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Hung hims elf on his bout 28c. Injury at Work? 27. Manner of Death 28b. Time of himself on his Injury 1 Natural 5 Pending 08/8 1 Yes 2-No death. investigation actober 19 2006 2 Accident I Director: / 6 Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number City or Town, State) 1315 Edge world filled in by within 24 hours after To the Funeral Direct 4 Homicide boat Annapolis Ham land Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medicai (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) HO053927 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SU 2754 Hamble V87 31. Date filed (Month, Day, Year) 32 degistrar's Signature 20740 State 2 4 2006 Registrar

State of Maryland / Department of Health and Mental Hygien 35592 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** October 22, 2006 11:00 A.M Arlyenne Switzer /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 4832 Briscoe Road Calvert St. Leonard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 K F Yrs. 538-12-8350 March 31, 1924 North Dakota Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show the Medical Examiner must be notified at 1 Tyes 2X No Directo Maryland | Calvert St. Leonard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a 20685 United States 4832 Briscoe Road death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. soft Ham 27 Is marked other than "natural", or Ite 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No by Specify: White 3€ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 civil servant U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Otto Peder Hans Brandt Ethel Bertha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31607 102 Ave. S.E., Auburn, Washington 98092 Mervin Johnston (Nephew) 20b. Place of Disposition (Name of cemetery, crematory or other placeOct 24 2006 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If Its any injury or ot once. 1 ☐ Burial 2 ②Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Funeral Service Alexandria Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 4405 Broomes Island Road, Port Republic, Maryland 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Colon CANCER **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) physicien and s the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical the guipt IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate hes hirector, page 2 s performed? res 2 No 1 Yes 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No After the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification; 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident death. 1 Yes 2 No Director: / 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 10051242 30. Name and address of prison who completed cause of death (Item 23a) (Type, Print) 110 Hospital Road, Suite 310, Prince Frederick, Maryland 20678 J. John Barth, MD 31. Date filed (Month, Day, Year) 32. Registrans Signature State OCT 2 6 2006 Registrar

State of Maryland / Department of Health and Mental Hygien  $200\,$ 

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 200<sup>Yea</sup> **Physician** October 23, 2:23 P.M Marian Rosalie Sweeney /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Calvert Memorial Hospital Prince Frederick Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🏋 F Yrs. 1931 Maryland 11, Director 219-56-0671 74 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County s or 28e-f show be notified at 1 Yes No Directo Maryland Calvert Lusby 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "neturel", or iteme 23a or edical Examiner must be United States 20657 8315 Cedar Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Peges 1 end 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 112 Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Me Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales <u>Assistant Manager</u> 12 other if Heelth and Menta! Hyg Item 27 le marked othe other treumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Blanche Walker Joseph Greenburg Sweeney ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8315 Cedar Lane, Lusby, Maryland 20657 Lucy Virginia Sweeney (Sister( 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition ō <u>=</u> ☐Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Depertment of Importent: If eny injury or once. Resurrection Cemetery 10/27/06 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service 4405 Broomes Island Road, Port Republic, Maryland 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician 404 OX resulting in death) /Medical Due to for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours effer death.
Funeral Director: After this certificate hes been signed by the ettending physicien end tely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the undertying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To the within 24 hours enes.
To the Funeral Director 28t. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examination On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie completed cause of death (Item 234) (Type, Print) 30. Name and address of person 31. Date filed (Month, Day, State 2006 6 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Reg. No. UU6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 23, 2006 Ralph Charles Smith 3:15 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Calvert County Nursing Center Calvert Prince Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 X M 2 □ F 164-24-5294 76 Jan. 6, 1930 Pennsylvania Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itama 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 🎾 No Director Maryland Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 493 San Antonio Drive 20657 United States filed within 72 hours after death v Hygiene. hther then "naturef", or items 236 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 27 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: by Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w
Department of Heelth and Mental Hygien
Important: if Itsm 27 is marked other the
any injury or other treumatin 12 Service Technician Necular Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Parker Smith Margaret Moiser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor R. Smith (Wife) 493 San Antonio Drive, Lusby, Maryland 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 10/25/06 Alexandria, Virginia 21. Signature of Funeral Service License 22. Name and Address of Facility Rausch Funeral Home, P.A. 4405 Broomes Island Road, Port Republic, Maryland 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) -ardiac Physician /Medical Due to (or as a consequence of): Examiner Cardiomyopathy Ischaemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Due to (or as a consequence of) Examiner the attending physiclen and hed for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) TYAS 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Atrial 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No ဥ 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mannet of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 ENatural 5 Pending investigation within 24 hours efter death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 50653 10-24-2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURANA GYAN .C. Deale 31. Date filed (Month, Day, Year) 32. Registra Signature State 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physicia		Registrar  1 Decedent's Name (First, Middle,	_ast)						2. Date of Dea	ath	3. Time of Death
Medical Exami	ner	DAY SHA	MARQUEE	SAV	OY	I			Month October 2	21, 2006 4c. County o	2028 nrs
		4a. Facility Name (if not institution, Washington County Ho				Hagers		ation of Death		Washing	
Funeral				e (In yrs. la	ast birthday)	If Under		f Under 24Hrs	8 Date of B	rth (MM/DD/YYYY	9 Birthplace (State or Foreign
Director		218-67-7066	M 2XF	3	Y	/rs Months	Days	Hours Min	SEPT	23 2003	Country) MARYLAND
<u>s</u> .		Usual Residence of Decedent  10a State 10b County		10c City	Town or Loc	ation					10d Inside City Limits
d bow ar			NGTON		ERSTOW						1 X Yes 2 No
larylan	Director	10e. Street and Number				10f. Zip (	Code	-		10g. Citizen of Wh	rat Country?
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r death with the Maryland or items 23a or 28a-f show any must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Mar	12. Was Decedent Armed Forces					ic Origin? (Sp exican, Puerto	ecify Yes or N Rican, etc.)	0- 14. Race White	- American Indian, Black, e, etc.
ter dea ", or if			1 Yes 2	X No	1	Yes 2	No st	pecify.		Specify:	BLACK
ours af atural	d by	15 Decedent's Education (Specif	or Dates.	npleted)	16a. Deced	ent's Usual C		(Give kind of v		16b. Kind of Bus	
6 n 72 ho an "n;	lete	Elementary/Secondary (0-12)	College (1-4 or	5+)			ang me. bo	NOT use rem	rea)	NONE	
21215-0036 uld be filed within 7 Mental Hygiene marked other than	Completed	0 17 Father's Name (First, Middle, L	ast)		NON	£	18.1	Nother's Name	(First, Middle,	NONE Maiden Surname)	)
215 oe filee ntal Hy ked o	Be	DERRICK SAVOY	,					AMBER	SIMMO	NS	
21 hould I hould I is mar itic ev	ဥ	19a Informant's Name/Relationshi									n, State, Zip Code)
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other transmatic event, the Medical Examiner must be notified at once		AMBER SIMMONS/ 20a. Method of Disposition	MOTHER	20b.	Z4 E Place of Disp				Date Date		MARYLAND 21740 City or Town, State
Baltimore, permit Pages I an Department of He Important: If ite		1 X Burial 2 Cremation		are	crematory or				00.06	OT TARMON	T MADS/T AND
Baltim permit Pa Departmen Importan injury or		4 Donation 5 Other Spe 21. Signature of Funeral Service L		RE	SURREC 22	. Name and			28-06 B. JEI		N,MARYLAND NERAL HOME
		X-D-14	-hall			7474 I	LANDOV	ER ROA	D LANDO	OVER, MARY	YLAND 20785
Physician /Medical		23a Part I. Enter the disease, or of failure. List only one cause of	each line		. Do not ente	r the mode of	f dying, suc	h as cardiac o	r respiratory ar	rest, shock, or hea	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a Seizure dis		of):						Deali
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110	nine	of any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	equence o	ıf):						
uted uted id ransit	Examiner	events resulting in death) Last	Due to (or as a cons	equence o	rf):						
ox 68760, eath certificate be executed attending physician and for use as the burial - transit	dical	X UNPENDED	AMENDED #2	Ba,27,	perME, g	2862, 12	2/14/06	TT			
68760, certificate bunding physics se as the bun	Physician/Me	IF FEMALE 23b. Was decedent pregnant in the	23c. If yes, outco		nancy	Fetal death		Ectopic pregna	ancy	23d Date of Month	delivery  Day  Year
Box 6	sicia	past 12 months?  1 Yes 2 No 9 Unkn	4 Pregnant a	t time of de	ooth	Other (Spec	ify)				
b. Be the de sy the sy the	Phy	Part II. Other significant condition	9 OHKHOWH	h but not r	esulting in the	e underlying	cause giver	n in Part I	23e. Did	tobacco use contri	ibute to the cause of death?
<b>b, P.O.</b> ires that the signed by	d by				_				1 Ye	es 2 🗸 No 3	Probably 4 Unknown
Records, The law require ficate has been si	Completed								24a Was		Were autopsy findings available prior to completion of cause of
tal Reco cian: The law certificate has	omp										death? ✓ Yes 2 No
tal Risian: Certific	BeC	25 Was case referred to medical examiner?	Hospital:				Oth	Death (Check			
of Vi	5	1 ✓ Yes 2 No 27. Manner of Death	inpati		ER/Outpatie		DA Oth	7	g Home 5	Residence 6 how injury occurre	Other:
on of anding Ph	tion:	1 X Natural 5 Pendii		Year)		, ,		2 No		. ,	
Division of Vital ral or Attending Physician: Is after death all Director: After this certical led in by the funeral director	ertification:	2 Accident Invest 3 Suicide 6 Could	28e Place of I	njury - At h	I ome, farm, st	reet, factory,	office build	ling, etc.	28f. Location or Town,		er or Rural Route Number, City
Division Hospital or Attent 44 hours after death Funeral Director: tely filled in by the	Cert	4 Homicide determ	(Opcony)								
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	29a Certifier 1 Certifying Phyone) 2 Medical Exam	sician: To the best of n iner: On the basis of exa and manner stated	ny knowled amination a	lge, death oco and/or investi	curred at the gation, in my	time, date a opinion, de	and place, and eath occurred a	I due to the cau at the time, date	use(s) and manner e and place, and d	as started lue to the cause(s)
F 3 F 8	Me	29b. Signature and title of certifier				29c	. License ni				ed (Month, Day, Year)
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AC.		30. Name and address of person v Mary G. Ripple MD.	he completed cause of Deputy Chief Med			11 Penn	Street, B	altimore, N	<b>1</b> D 21201		
	tate	3 Nov illed (2002006 Year)	32 Registra	ar's Sunat	ure						
Regis	trar	1101 0	The same of the sa	11							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #23 P11 State of Waryland 50 epartment of Health and Mental Hygiene Certificate of Death Reg. Ne. U 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2006 18 8:35 P Harold Xavier Smith October /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's 913 Shady Glen Drive Capitol Heights 7. Age (In yrs. last birthday) II Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours 1**X**M 2□ F Yrs. Dec. 12, 1943 Director Tennessee 206-32-7163 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 28e-f ehow the Medical Examiner must be notified at 1XYes 2 □ No Director Capitol Heights Prince George's Maryland | 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 20743 United States or Items 23a 913 Shady Glen Drive Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 XYes 2 □ No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Specify: þ 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Government permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygien important: if Item 27 is marked other than y injury or other treumatic event, III.s once. 2 DC Police 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Bigelow Franklin Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 913 Shady Glen Drive, Capitol Heights, MD 20743 Dollie J. Morina-Smith/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other placem. 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/25/2006 Washington National Suitland, MD 22. Name and Address of Facility 21. Signal re of Funeral Service Licensite Stewart Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myelogenous Leukemia 4001 Benning Rd., NE Wash., DC 20019 Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Be Completed by Physician/Medical for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) P.O. ete has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown <u>Multiple Sclerosis</u> 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XNo 2□ No 1 ☐ Yes 1 TYes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) After this cr funeral dire 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No death. ctor: Al 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, larm, street, lactory, office building, etc. (Specify) after d 4 Homicide To the Hospital within 24 hours a To the Funerel C completely filled 🗴 Cartifyling Physician: To the best of my knowledge, death decurred at the time, date and plane, and due to the newse(s) and manner as stated 29x Cortfol 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Emperiloan MD

State Registrar

C. Vergara-Soares, M.D. 9940 Franklin Square Dr., Baltimore, MD 82. Registrar's Signature

30. Name and addr of ol person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 2006

D16619

October 23, 2006

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of Marylan		nt of Health and late of Death		iene2006	35598
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Las <u>CheSter</u> 4a. Facility Name (If not institution, give	Rooseve	·	no Field y, Town, or Location of Deat	2. Date of Death Month Octobe v	Day Year	
	Funeral Director		217-12-6927		last birthday) If Und Month	er 1 Year If Under 24 Hrs s Days Hours Min.	8. Date of Birth (Month, Day, Se. pt. 15	Dorche Year) 5,1914 M	ester  hplace (State or Foreign  unity)  aryland
5	death with the Maryland me 23a or 28a-f ehow count be collined at	rector	Usual Residence of Decedent  10a. State 10b. County  Talk  10e. Street and Number			V A	10	0g. Citizen of What Co	10d. Inside City Limits 1 ☑Yes 2 ☐ No
36 K		by Funeral Director	10455-Counce/, 11. Marital Status 11 Never Married 2 Married 3 Widowed 4 Divorced	ROQJ  12. Was Decedent Ever in U Armed Forces?, 1 □ Yes 2 ₺ No If Yes, Give Year or Dates:	1	2/6 2 5  edent of Hispanic Origin? (S edity Cuban, Mexican, Puerl 2 No Specify:	pecify Yes or No- to Rican, etc.)	14. Race · Ame Black, Whit	e, etc.
21215-0036	be filed within 72 hours after Ital Hygiene. Ind other then "nature!", or ite event, the Medical Examina	Completed t	15. Decedent's En (Specify only highest gra Elementary/Secondary (0-12)	lucation		vork done during most of wo use retired)	rking	Self-em	,
Maryland	S should be filed wi and Mental Hygien Is marked other th eumatic event, the	To Be (	17. Father's Name (First, Middle, Last)  19a. Informant's Name/Relationship (	• •	19b. Mailing Addre	18. Mother's Nat 15 a l ss (Street and Number or Re	ne (First, Middle, N belle )	Maiden Sumame)	
Baltimore, M	Health Health tem 27 other tr		20a. Method of Disposition  102 Burial 2 Cremation 3 C 4 Donation 5 Other (Specific	Removal from State	10455-C Place of Disposition (No cometery, crematory of	r other place)	Date 2	Maryland 20c. Location - City or Traffe, Mo	Town, State
Balti	permit. Pages Department of Important: If it eny injury or once.		21. Signature of Funeral Service Licer  Augustia  23a. Path. Enter the disease, or com	C. Devry	Hen in 510 h	and Address of Facility 14 Furueral 1 10 Sh. rugton St.	Home, P. A. Cambrid	ae MD. 2	1613 Approximate
	Physician and wasician and hysician and hysi	Ical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line.  L U  Due to (or as a consequence)	ung Car quence of): Vance D quence of).	(cr eserhi		Ta .	Interval Between Onset and Death
P.O. Box 66	ne death certifica the attending planed for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of pregnative birth 2 Feta 4 Pregnant at time of c	al death 3 □Ectopic			23d. Date of del Month	ivery Day Year
ords, P.	n requires that the been signed by should be detact	Ď	Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlying	cause given in Part I.		pacco use contribute to es 2 □ No 3 □ Pr	o the cause of death?
Division of Vital Records,	icien: The law certificate as b rector, page 2 st	e Completed	25. Was case referred to medical			26 Place of De	24a. Was ar autops: perform 1 Yes 2	y prior to death? 1 ☐ Yes	utopsy findings available completion of cause of
Ş	ysicie is cer direct	To Be	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	Tou -		once 6 □Other (Spe	city)
0	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	· · · · · · · · · · · · · · · · · · ·	w injury occurred	
Divisio	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined		M ome, farm, street, fact fy)	1 □ Yes 2 □ No	28f. Location (Str City or Town	reet and Number or Ri n, State)	ural Route Number,
	Hosp 24 hou Fune tely fil	Medical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exar	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurr ation and/or investigati	ed at the time, date and place on, in my opinion, death occi	e, and due to the ca urred at the time, da	ause(s) and manner as ate and place, and due	s stated. e to the cause(s)
	To the within To the comple	Mec	29b. Signature and title of certifier	A.c.A		gc. License number		9d. Date signed (Mont	
			30. Name and address of person who	completed cause of death (Iter	m 23a) (Type, Print)	047924		10.25-0	La
			MOMBY THANWY  31. Date filed (Month, Day, Year)		A ST CA	MRRIDGE	MD 2	-1613	
	Sta Regist	ate rar		6 2006 D	N An	L)			

			State of	Maryland / Department of Health and Menta	Hygiene
		-	_ State	Certificate of Death	2000 2000
			1. Decedent's Name (First, Middle, Last)		e of Death 3. Time of Death
	Physicia	in	Charles Alexande	r Streeter Oct	nth Day Year 1010 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and numb	1	4c. County of Death
	Examin	<b>e</b> 1	Dorchester General	Hospital Campridge	Donchester
	Funeral		5. Social Security Number 6. Sex 7.		e of Birth 9. Birthplace (State or Foreign Country)
	Director		213-44-0134 10M 20F	6 / Yrs. World Ju	
7	2 2		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Location	10d. Inside City Limits
1	sho	5	1	00001-100	1 ☑ Yes 2 ☐ No
7	286.	ecte	MD Dorchester  10e. Street and Number	101. Zip Code	10g. Citizen of What Country?
- 1	0 0	흡	911 Central A	2/6/3	USA
	is affer death with the Maryland I, or Itams 23a or 28a-f show Karring I must be rediffed at	Funeral Director	11 Marital Status 12. Was Deced	nt Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican,	
_ 3	or Ital		1 Never Married 2 Married 1 Yes 2	If Yes, specify Cuban, Mexican, Puerto Hican, 4  I □ Yes 2 II No Specify:	etc.) Black, White, etc.
900	E S	à	3 ☐ Widowed 4 ☐ Wivorced If Yes, Give Year or Date		Black
ה ל	natural', dical Exp	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
2	9 4 9	쿹	Elementary/Secondary (0-12) College (1-4	or 5+)	Francos
V	ther t	ပ္ပ	17. Father's Name (First, Middle, Last)	Transportation  18. Mother's Name (First.	Entrepreneur  Middle, Maiden Sumame)
מום	ntal lied of	00	- Carlotte	l'ams Lucille	Alice Streeter
<b>S</b>	mark meti	၉	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route	
<b>∑</b> 3	s I end 2 shoul ! Heelth and Me !tem 27 is mar! other traumsti		Tunell D. Strep.	ter 522 Mathews Ave, Brog	1K/4NPark, MD, 2/225
ත	t Hee		20a. Method of Disposition	20b. Place of Disposition (Name of Date	20c. Location - City or Town, State
Ê.	reges ment of ant: If I		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from St `4 ☐ Donation 5 ☐ Other (Specify)	Smithville Comptery 10/26/	06 Taylors Island MD
= = = = = = = = = = = = = = = = = = =	pertm ports y inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility, HENRY FUNERUI HOME,	
מ	88 2 2 3		Janelle (. )	Acrows 5 in lingh ination st	Cambridge, VIDE 21613
			23a. Part1. Enter the disease, or complications that cau shock, of heart failure. List only one cause on each	sed the death. Oo not enter the mode of dying, such as cardiac or respir h line.	atory arrest, Approximate Interval Between
F	hysician		Immediate Cause (Final disease or condition	LATED CARDIOMYOPATH	Olisot and Boatin
	/Medical Examiner		resultant in death)	as a consequence of):	2
		L	Sequentially list conditions, b. Due to lo	as a consequence of):	30 years
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	25 2 05/155440/150 01/.	,
	be executed sicien end burlal-transit	xar	that initiated events c.	as a consequence of):	
9	ysicien en	cal	d		
	g phy es the				
Š Ž	death certifica e ettending ph id for use es th	<u>Z</u>	IF FEMALE: 23c. If yes, outco	me of pregnancy n 2 □ Fetel death 3 □Ectopic pregnancy	23d. Date of delivery
מ	neeat ne ette ed for	300	in the past 12 months?  1 ☐ Yes 2 ☐ No	t at time of death 5 Other (specify)	Month Day Year
O	at the	Physician/Med	9 Unknown		e. Did tobacco use contribute to the cause of death?
'n	ine law requires ther the death Sertilica ste hes been signed by the ettending ph bege 2 should be deteched for use es th	5	Part II. Other significant conditions contributing to dea	AS \ 0 M	1 Yes 2 No 3 Probably 4 Unknown
Records,	need ponic	eted	1		
စို -	sician: The law certificete hes t irector, pege 2 s	Completed	H5th ma		a. Was an autopsy findings available prior to completion of cause of death?
			OF Management of the control of		Yes 2XNo 1∐Yes 2UNo
VITAL	rnysician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Ing	26. Place of Death (Chec atient 2 ★ ER/Outpatient 3 □ DOA Cther: 4 □ Nursing Home 5	Residence 6 □Other (Specify)
	rnys er this eral di	n: To	27. Manner of Death 28a. Date of	njury 28b. Time of 28c. Injury at 28d. De	scribe how injury occurred
Division	Attending ir death. ector: After by the fune	atlo	1 Natural 5 Pending (Month, 2 Accident investigation	Day Year) Injury Work?  M 1 ☐ Yes 2 ☐ No	
S :	r Attending Phy fer death. Irector: After this by the funeral o	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place o building		cation (Street and Number or Rural Route Number, y or Town, State)
5 ;	rs after or	Cer			
	e Hospitel or 24 hours afte e Funsrel Dir letely filled in	cai	(Check only 2 Medical Examiner: On the bas	est of my knowledge, death occurred at the time, date and place, and due s of examination and/or investigation, in my opinion, death occurred at th	e to the cause(s) and manner as stated. e time, date and place, and due to the cause(s)
	To the Hospitel or Attendi within 24 hours after death. To the Funsrel Director: A completely filled in by the to	Medicai	one) and manne  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
1	8 4 \$ -		1 7 4 0 1	D53253 MD	10-24-06
			30. Name and address of person who completed cause	uer	
			Timothy Sniezek M	D 136 Lednum AVE 1	Preston, MD 21655
P\$.	Sta			istrar's Signature	
	Registr	-	III. Z D ZUUO PRAL	an a file files of	

			For State Registrar	State of Ma	aryland		rtmen <i>tificate</i>			and Me		giene Reg. No	Z 1111	6	35600
		_	1. Decedent's Name (First, Middle, Last)								2. Date of Dea	ath Da	y Yea		3. Time of Death
	Physici: /Medic		Leola M. Smith								October	r 18	, 2006		9:05p M
p	Examin		4a. Facility Name (If not institution, give	street and number)					Location o	of Death		4c. County of Death			
			Suburban Hospital  5. Social Security Number 6. Security Number	7 400	a /In urs I	ast birthday)	If Under	hesd	a. If Under 2	24 Hrs.	8 Date of Bird	Montgomery  Birth 9. Birthplace (State or Fore.			a /State or Foreign
	Funeral Director				80	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da March	Z. Tear)	1926	Country)	inia
7			Usual Residence of Decedent												
oelvas	/2 nours after death with the Maryland natural', or Items 23a or 28a-f show dical Examinar must be notified at	_	10a. State 10b. County		· 1	, Town or Lo								10d.	Inside City Limits 1 X Yes 2 No
M		Director	D.C. N/A		Was	shingto	0 <b>n</b> 10f. Zip	Codo			····	10a Cir	tizen of What	Country	
i.		급	4921 4th Street,	N.W.				011				1.7	ted St		
death		by Funeral		12. Was Decedent	Ever in U.:		Vas Deced	ient of His	spanic Orig	gin? (Spec	rify Yes or No		14. Race - A	nerican	Indian,
9	or Ite	Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 23€1 If Yes, Give	No		r Yes, spec		Specify:	і, Риепо н	lican, etc.)		Black, W Specify: B		
E00	permit. Pages 1 and 2 should be lifed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-1 show any injury or other traumatic svent, tra Medical Examinar must be notified at once.	d b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	-										
15-0		To Be Completed	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i>		16a. Deced (Give life. L	lent's Usua kind of wor DO NOT us	rk done d	urina most	t of workin	g	16b. K	ind of Busine	ss/Indus	try
212			Elementary/Secondary (0-12)	College (1-4or 5	i+)	Hor	nemak	er				Dom	estic		
ם כ			17. Father's Name (First, Middle, Last)		,				18. Mothe	r's Name	(First, Middle,	Maider	Sumame)		
ylaı			Mose Holliday							Col.					
Mar	and and le m		19a. Informant's Name/Relationship (Ty				-				Route Number	_			
e, 1	Health Bm 27 ther t		Denise Smith-Gray  20a. Method of Disposition	e (daugh		1304 lace of Dispo			E. N.		Washing		ocation - City		O10 State
nor i	nt of transfer of or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	ı	emetery, cren antico	-		3)	10/27/	/2006		angle,		
劃	ortsn injur		21. Signature of Funeral Service Licens	99,					s of Facilit	y McG	uire Fu				
m i	Depa Impo eny i		Inche J	hongeson	~	74	400 G	eorg:	ia Av	e. N	.W., Wa	shi	ngton,	D.C	. 20012
	Physician //Medical Examiner parial-transit		23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	ications that caused ne cause on each lin	the death	. Do not ente	er the mod	e of dying	, such as	cardiac or	respiratory ai	rrest,		1nt	oproximate terval Between
			Immediate Cause (Final disease or condition Pneumonia Onset and Death 3 days												
			resulting in death)	Due to (or as	a consequ	uence of):									
		-	Sequentially list conditions, if any leading to immediate  b.  Due to (or as a consequence of):								+				
		Examine	cause. Enter Underlying Cause (Disease or injury that initiated events  c.												
oʻ		Еха	resulting in death) Last Due to (or as a consequence of):												
8760,		dicai		d											
9 x	ding p	/Me	IF FEMALE:	3c. If yes, outcome	of oregna	ncv							Old Data of	dalissa.	
Вох	Attending Physician: The law requires that the death certific robath. robath. sctor: After this certificate has been signed by the attending p sctor: After this certificate has been signed by the funeral director, page 2 should be detached for use as	Physician/Me	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3	Ectopic pr Other (sp						23d. Date of o Month	Da	y Year
0		ysi	1 ☐ Yes Ø⊠No 9 ☐ Unknown	9□ Unknown											er 110 - 20
G		by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Metastatic Endometrial Carcinoma, Anemia						23e. Did to	23e. Did tobacco use contribute to the cause of death?					
ord		Completed						101	1 Yes 2 No 3 Probably 4 Unknown			y 4 Unknown			
ecc											24a. Was autop	OSV.	prior t	o compl	findings available etion of cause of
<u>=</u>											1 Yes	med?	death		□ No
of Vital Records,		Be	25. Was case referred to medical examiner?	lospital:				Othe	r		(Check only o		. =		
ō		٦: <u>۲</u>	1 ☐ Yes 2 🛣 No 27. Manner of Death	28a. Date of Inju	ιγ	ER/Outpatien 28b. Time of		JA	4   190		le 5 ☐ Reside l			Decify)	
ion		ation	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury			28c. Injury at Work?  M 1 Yes 2 No								
Division	or Attendations of the properties of the propert	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj	ury - At ho	ome, farm, str	eet, factory	y, office		2	8f. Location (. City or Tox			Rural R	oute Number,
	urs afte rel Dir														
	is Hospital or a 24 hours after is Funeral Dira	edicai	29a. Certifier 1 ☑ Certifying Phy (Check only 2 ☐ Medical Exami one)	sician: To the best ner: On the basis o and manner sta	f examina										
	vithin 2. To the complet	×	29b. Signature and title of certifier				290	c. License	number			29d. Da	ite signed (Mo	onth, Da	y, Year)
	10		the tay	_ MD			D	0060	117			0ct	ober 20	0, 2	006
	•		30. Name and address of person who c	•	death (Item			_ 1	a - ·				1	0.0	0.50
	Sta	ate.	Eric J. Park, M.D 31. Date filed (Month, Day, Year)	32 Registr	ar's Signa	ture /	Medi	cal (	ente	r Dr	, Rock	CVIL	re, MD	20	850
	Regist		OCT 2 4 2	006 Bra	1	S. A	Sec.								

October 18, 2006 2105 P.M.

SMITH, LEOLA

		. For	partment of Health and Ment	2006 35601					
		Registrer  1. Decedent's Name (First, Middle, Last)	ate of Death 3. Time of Death						
Physic		Joseph Melvin Shamwell	tober 17 2006 1348 M						
/Medi Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death					
	\$0 <b>.</b>	9732 Wyman Way	yper Marloor	5 Prince George's					
Funeral Director		5. Social Security Number 578-56-1959  6. Sex 7. Age (In yrs. last birthday) 6. Sex 7. Age (In yrs. last birthday) 6. Sex	y) If Under 1 Year If Under 24 Hrs. 8. Days Hours Min. (M. Au.	ate of Birth fonth, Day, Year) g.29,1944  9. Birthplace (State or Foreign Country) Wash. D.C.					
and		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or I		10d. Inside City Limits					
Mary I-f sho	Ď,	Maryland Prince Georges Upper Mar	lboro	X□Yes 2□No					
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. Hygiene matural, or Items 23a or 28a-f show ent, the Medicel Examinar mant to rediffest at	by Funeral Director	10e. Street and Number 9732 Wyman Way	10f, Zip Code 20772	10g. Citizen of What Country? United States					
er death	unera		B. Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican	res or No- , etc.) 14. Race - American Indian, Black, White, etc.					
21215-0036 d within 72 hours aft gione. r than "natural", or!	d by F	1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Never Married 2 No 1969 - If Yes, Give Year or Dates: 1972	1 ☐ Yes 2 ☐XNo Specify:	Specify: Black					
15-C	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation ve kind of work done during most of working . DO NOT use retired)	16b. Kind of Business/Industry					
212 d with gione.	mo.	Elementary/Secondary (0-12) College (1-4or 5+) 4 Mark	eting Director	Disney, Inc.					
Maryland of the stand that and Mental Hyg	Be	17. Father's Name (First, Middle, Last) William H. Shamwell	18. Mother's Name (Firs Virginia Jo	it, Middle, Maiden Sumame) ohnson					
should merk	2	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Street and Number or Rural Rou	ite Number, City or Town, State, Zip Code)					
and 2 salth a n 27 is		The state of the s	Wyman Way, Upper Mar.						
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or Items 23a or 28a-f show important of other traumatic event, the Modical Enamination at Exciting at ance.		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	position (Name of Pare) ham Veterans 10/24/06	6 Cheltenham, MD					
Balti Permit. Departm Importe any inju				ire Funeral Service, Inc, Washington, D.C. 20012					
		23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each fine.	inter the mode of dying, such as cardiac or resp	piratory arrest, Approximate Interval Between Onset and Death					
Physician /Medical		Immediate Cause (Final disease or condition a. Atherosclerotic CArdiovescular Heart Disease							
Examiner		Due to (or as a consequence of):							
₽ ₩	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying							
760, be executed sician and burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of):							
2 2 2	cat	<u>s</u>							
r 68 ortifica ing ph	Med	IF FEMALE:		No.					
hat the death certificat that the death certificat ed by the attending phy detached for use as the	Physician/M	23b. Was decedent pregnant  1 Live birth 2 Fetal death	3⊡Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery  Month Day Year					
dS, P.	by Ph	Part If. Other significant conditions contributing to death but not resulting in the	23e. Did tobacco use contribute to the cause of death?						
cord w requir				1 Yes 2 No 3 Probably 4 Office available					
Re la	Completed			24a. Was an autopsy findings available prior to completion of cause of death?  □ Yes 2 □ No  24b. Were autopsy findings available prior to completion of cause of death?					
of Vital F Physician: Th ribis certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Che						
	7: To	1 ☐ 7es 2 ☐ No	of 28c. Injury at 28d. I	5 Residence 6 Other (Specify) Describe how injury occurred					
Vision of Attending Ph (death.	ation	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	y Work? M 1 ☐ Yes 2 ☐ No						
in Diffic	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Pface of Injury - At home, farm, building, etc. (Specify)	ocation (Street and Number or Rural Route Number, City or Town, State)						
Hospite 4 hours Funeral ely fille	edical C								
To the I within 2. To the I complet	<b>⊠</b>	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)					
15		Salada Spreete Do	140-55927	October 20, 2006					
-		30. Name and address of person who completed cause of death (Item 23a) (Typ	pe, Print)	, man land					
1 10 T	ate	SALVASON SYNSTER 3001 HOS PIT  31. Date filed (Month, Day, Year)  OCT 2 4 2006  Salvason Market Signature	and only	THE THE PERSON OF THE PERSON O					
Regis		OCT 2 4 2006 Beau & A	parell						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician Charles Titus SHIFLER 2006 October 1644 М /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year) Washington 19228 Swinging Bridge Road Boonsboro If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1⊠M 2□F Yrs Maryland 217-16-2596 84 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mantal Hygiene.

and: if them 23s or 28se-1 show and it if them 23s or 28se-1 show and it if the notice them marked other than mature!, or items 23s or 28se-1 show any or other treumstic event, it is inclined in 1 Yes 2x No Boonsboro Director Maryland Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21713 USA 19228 Swinging Bridge Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify white 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 laundromat 12 owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Amanda Kathryne Mentzer Hubert Isaac Shifler, Sr. ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19228 Swinging Bridge Road, Boonsboro, Md. 21713 Blanche Shifler - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: if ony Injury or once. Rose Hill Cemetery 10/28/06 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service License Mame and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 Approximate Interval Between Opset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** ear /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Exami and Due to (or as a consequence of) attending physicien for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ page 2 should be 3 ☐ Probably 4 Munknown 1 ☐ Yes 2 ☐ No Completed peed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 X No has certificate 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) After t Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 2 🗆 No 1 Tes 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature 00056826 address of person who completed cause of death (Item 23a) (Type, Print) 30. N

Registrar DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

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Box 68760.

P.O.

Division of Vital Records.

32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Da **Physician** Noble Lee Simms October 25, 0305 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Caroline Nursing Home Denton Caroline If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 ☐ M 2 ☐ F Months 93 Director 219-07-6159 12. 1913 Maryland Usual Residence of Decedent Maryland or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits XXYes 2□No MD Caroline Denton Directo the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ital Hygiene. ad other than "natural", or Items 23a or: event, I'm Medical Examiner must be r Pages 1 and 2 should be filed within 72 hours after death with 520 Kerr Avenue United States 21629 by Funerai 12. Was Decedent Ever in U.S. Armed Forces?

↓□Yes 2□No

ff Yes, Give 1
Year or Dates: 44-46 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3√Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Agriculture/Caroline Elementary/Secondary (0-12) College (1-4or 5+) Farming/School Bus Driver Co. Bd. of Education 5 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental Hitem 27 is marked oth rother treumatic even Be Manship Simms Susie Simms Boss 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 716 W. Ivy Drive, Shirley Woolford/Daughter Seaford, DE 19973 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State to = : 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. 10/31/06 Hurlock, Maryland Eastern Sh. Veterans \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom, Funeral Home, P.A. 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 2532 Nichael 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 0 Physician en disease or condition resulting in death) Nears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) sate has been signed by the a page 2 should be detached to o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 ☐ Yes 2 ØNo 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Division of Vital To the Hospitel or Attending Physicien: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No 24 hours after death.

Funerel Director: A investigation filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie DO047534 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Denton, MD 21629 920 Market St. Wafik Zaki, M.D 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 30 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month O Goldaboro K. Starling **Physician 2**5 17 05 M 3006 /Medical acility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** ininsua Kegional Medical Center Salisbur Wicomico Birthplace (State or Foreign Country) If Under 1 Year | If Under 8. Date of Birth (Month, Day, Year) **Funeral** 1**⊠**M 2□F 212-14-4335 MARYLAND Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 No Md. SOMERSET **Funeral Director** 10f, Zip Code 10g. Citizen of What Country? 10e, Street and Number d other than "natural", or items 23a or event, the Medical Examiner must be a U. S. A. 21838 29419 LOVERS LANE 12. Was Decedent Ever in U.S. Armed Forces? 1 Dives 2 □ No 7 - 21 - 44 If res, Give Year or Dates: No 6 1945 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify: BLACK Maryland 21215-0036 Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) JOHN T. HAOY Elementary/Secondary (0-12) College (1-4or 5+) -Line worker Crab-cutter SCAFOOD INClustry s 1 and 2 should be filed wi f Health and Mental Hygien item 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anderson Sterling am ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Sterlin 29419 Lovers Lawe 21838 Marjon, mel Department of Health Important: If item 27 any Injury or other tr. wife 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 10-28-06 Marion . FAMILY Cemetery 22. Name and Address of Facility
Bennie Smith towered Home
917 W. Fsabella St. Salis 21: Sign Lucy of Funoral Service Licensee md 21801 SALISBURG 23a. Part1. Erter he disease, o shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus (I nal disease or conditi resulting in death) Pasamonia Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (bisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed and burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical the SS for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f P.O. 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ HypsHension, Dimondia 1 Yes 2 No 3 Probably 4 → Nown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has t page 2 s autopsy 2 No After this certificate Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director. F 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

BA 3+1

State Registrar

31. Date filed (Month, Day, Year)

OCT 24 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, 107 Piùs Bruff, Str7, Salebum, MDZ1841 Michael Crouch MD egistrar's Signature

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			State of Maryland / Dep	artment of Health and Mer	-	•					
			1 - State Registrer Certificate of Death Reg. No. 2006 356								
			Decedent's Name (First, Middle, Last)	Date of Death		3. Time of Death					
	Physic /Medi		Frances Josephine Sappington	000	et. 19	, 2006	10:30 a <sup>M</sup>				
	Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death						
			Glen Burnie Health & Rehab  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)	Glen Burnie  If Under 1 Year   If Under 24 Hrs.   8.	Data of Birth	Anne Arundel					
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 1 M 2 X F 85 Yrs.	Date of Birth (Month, Day, Yean, 3, 1	9. Birthplace (State or Foreign Country) MD						
	and w	tor	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ocation			10d. Inside City Limits				
Baltimore, Maryland 21215-0036	Maryli P-f sho		MD Anne Arundel	Pasadena			1 ☐ Yes 2 ☐ No				
	or 28	<b>Funeral Director</b>	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Co					
	eath v	era	104 W. Hamburg Street	21122	. Van ar Na	USA					
	ter d	II.	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 ▼ No	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	an, etc.)	14. Race - Amer Black, White					
	rei', or	þ	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: W	nite				
	filed within 72 hours after death with the Maryland Hygiene. uther than "naturel", or items 23e or 28e-f show inthe than "naturel", or items 25e or 28e-f show ont, I'm Medical Evar it at must be notified at	letec	(Specify only highest grade completed) (Give	edent's Usual Occupation a kind of work done during most of working DO NOT use retired)	16b	. Kind of Business/l	ndustry				
	d withi	To Be Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker		Home					
	be d fall be		17. Father's Name (First, Middle, Last) Charles Herpel	18. Mother's Name (Fi Selma EV							
	# \$2 mg			ing Address (Street and Number or Rural Ro Edgemere Drive, Ann							
	Pages 1 an nent of Heal int: If item 2 iry or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify)	osition (Name of matory or other place) ven Cemetery Oct. 2 200	23, 20c.	Location - City or 1 len Burni					
Balti	permit. Pag Department Importent: eny injury c		21. Si vature Funeral Sorvine Internaee	Name and Address of Facility P.A. 95 Gov. Ritchie Hwy,	Severn	a Park Fu a Park, M	neral Home D 21146				
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause, in each line. Interval Between								
			Immediate Cause (Final disease or condition resulting in death)  a. AORTIC STENOSIS  English and Death STENOSIS  E								
			ESSENTIAL HYPERTENSION 20YEARS								
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	te be executed ysician and be burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C. DIABETES MELL(TUS  Due to (or as a consequence of):								
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89		6	V								
. Box	death certificat e attending phy ed for use as th	Be Completed by Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☑ No  □ ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown		23d. Date of deliv Month	rery Day Year					
P.0	that the de led by the a detached t		9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in the u		23e. Did tobacco use contribute to the cause of death?						
	he law requires e has been sign age 2 should be		SANGRENE BOTH	FEET.	1 Yes 2 No 3 Probably 4 Unknown						
Records,					24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of				
Vital	sicien: T certificat rector, pa		25. Was case referred to medical examiner?	26. Place of Death (Ch							
<del>o</del>	S =	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 27. Manny of Death 28a. Date of Injury 28b. Time o		Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred						
Division	ding J. After fune	tlon	27. Manny of Death  1	f 28c. Injury at 28d. Work? M 1 ☐ Yes 2 ☐ No							
	or Atten ifter deat Director: in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined 28e. Place of Injury - At home, farm, str. building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
		Cer									
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one)  1								
)	To the withing the complete of		29b. Signature and title of writher the standard M.D.	29c. License number 14160	29d. C	Date signed (Month,	0ay, Year) 9,2006				
	3		30. Name and Andress of derson who completed day of day in (light 28a) (T) of BALT (	Print) SY10-ARITA	CHIE	HIGH	MAY,				
1	State Registrar  31. Date filed (Month, Day, Year)  12. 3 2006  31. Registrar's Signature										

State of Maryland / Department of Health and Mental Hygierie 5606 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1:30 AM 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday, **Funeral** Min. Days 1**X**M 2□F 16, 85 1921 Director 217-18-4378 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show 2 should be filed within 72 hours after death with the Maryla and Mental Hyglene and Mental Hyglene I be marked to the then "natural", or Items 23e or 28e-1 show summatic event, The Medical Even ill artificial committee in Milliad MD Anne Arundel 1 ☐ Yes 2 X No Severna Park Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 213 Hollyberry Road 21146 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No WWII 11. Marital Status Black, White, etc. 1 Never Married 21 Married White Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Ticket Agent Eastern Airlines 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental Reamer E. Sewell, Sr. Helen Chambers other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas E. Sewell/Son 213 Hollyberry Road, Severna Park, MD If item 27 3altimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Oct. 23 2006 Pages 1 23, 1 ☐ Buriai 2 X Cremation 3 ☐ Removal from State injury or Baltimore, MD Department of Important: If any injury or Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Sen Barrancod & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 10 years Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of) Box 68760, physician Physician/Medical the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy The law requires that the death in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) ber f o the 9 Unknown 9 Unknown signed by the sign of the sign مَ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 3 Probably 4 | Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? page 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Umpatient 3 DOA 2 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 Natural Injury 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 ☐ Homicide within 24 hours a 29a. Certifier 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) To the 29b. Signature ag AU4176435B17395 npleted cause of death (Item 23a) (Type, Print) N. Greene St., Baltimore, MD 21201 State

Registrar

State of Maryland / Department of Health and Mental Hygien ? Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** SMITH 1629 Louis 06 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BATTIMORE UNIVERSITY OF MARYLAND MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**∑**M 2□F Yrs 77 Jan 18 1929 West Virginia 234-44-2485 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10a. State 10c. City, Town or Location wor. rthan "naturel", or items 23s or 28s-f ehor the Medical Examiner must be notified at 1 Yes 2\0 Director MD Anne Arundel Gambrills 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 952 Central Lane 21054 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married Yes, Give Year or Dates: 1949-52 1 ☐ Yes 2 X No White Maryland 21215-0036 Specify: Specify: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Defense Analyst Item 27 le marked othe other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Howard F. Smith Cecelia A. Bobo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health Helga A. Smith (Wife) 952 Central Lane, Gambrills, MD 21054 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location · City or Town, State 20a. Method of Disposition Pages 1 permit. Pages Department of Important: If It eny injury or c 1XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vet Cem 10-23-2006 Crownsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) EREBRAL Physician VASCULAR ACCIDENT /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No ò 4 Pregnant at time of death 5 Other (specify) P.O. P ed by the a detached f 9 Unknown 9 🗌 Unknown signed l 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. δ 1 Yes 2 No 3 Probably 4 Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Minpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ၉ 1 ☐ Yes 2 No his After this funeral d 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours after To the Funeral Direct 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) the the 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 11096 151 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OWINGS Mills, MD CHOC 4600 AIGOTT WAY # 405 William OCT 2 0 2006 32 Registrar's Signature 31. Date filed (Month, State Registrar

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 0 35609 For State Registrer Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Oct 31, 2006 **Physician** Sell 2:45 am<sup>№</sup> Juanita /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death **Examiner** Cumberland Nursing Home Cumberland Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Feb 25, 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) Days Months Hours 1 □ M 2 □ F Yrs. Director 119-18-4222 93 1913 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits item 27 is marked other then "natural", or items 23a or 28e-1 show other treumatic event, if the Medical Exercity at most be notified at MD Allegany Cumberland 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12014 Marigold Avenue 21502 USA permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23s any injury or other treumatic event, the Medical Exercitivas manual. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 □XVidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Bliss Hardesty Gertrude Hauser Hardestv 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12025 Iris Avenue MD 21502 Mary DeStefano daughter Cumberland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Sunset Memorial Park 11/4/2006 Cumberland MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. 21. Signature of Funeral Service Licenses 108 Virginia Avenue; Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** anten CORDINA years disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 □ Pregnant at time of death 5 Other (specify) 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 NO 1 ☐ Yes To the Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 2 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 - Hatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Novemby 2, 2006 an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 924 Seton Drive Cumberland MD 21502 Vikramaditya Poonai M.D.
31. Date liled (Month, Day, Year)
32. Projectrar's Signatur State Registrar NOV 0 9 2006

State of Maryland / Department of Health and Mental Hygiene 35610 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 31, 2006 Robert Walter Sykes **Physician** 10:25 PMM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner College View Center Frederick Frederick If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth April 11, 1916 Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 15 M 2□ F 90 173-05-7690 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heelth end Mental Hyglene. Importent: it item 27 is marked other than "naturai; or items 23a or 28a-t show amy injury or other treumatic event, Ira Madical Examinar must be notified at once. Washington 1 ☐ Yes 2X No Maryland Sharpsburg Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3804 Mills Road 21782 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ Nd 942-1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White ģ If Yes, Give Year or Dates: Specify: 3℃Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Assistant Librarian Public Library 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Walter Sykes Catherine Sykes ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 240 Ansley Close, Roswell, Georgia 30075 Stephanie C. Long, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Acremation 3 Removal from State Smithsburg Crematory Nov. 2, 2006 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License <sup>22, Name and Address of Facility</sup> Keeney and Basford PA Funeral Home MO0255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 4-7000 ong enive resulting in death) /Medical Due to (or as a c nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ettending physicien for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificete 1 Yes 2 No 1 ☐ Yes 2 ☐ No --director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this if Director: After this d in by the funeral of 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending investigation death. 1 TYes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct completely filled in by determined 4 Homicide Conflying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 255 Certifier To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 1, D 576 43 Hirenov Shah 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick and 2/702 Thousan 65 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 09 Registrar 2006

**ORIGINAL** 

DHMH 17 Rev 1/2001

06-08118

## Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Brian Philip Spruyt 1- For State Certificate of Death Reg No. Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day October 28, 2006 1250 hrs **Medical Examiner** Brian P. Spruyt

4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 140 Mahogany Drive North East Cecil 5 Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8 Date of Birth (MM/DD/YYYY 9 Birthplace (State or **Funeral** Months Days Hours Min Director Country Wew York 101-58-5840 1 X M 2 44 March 31,1962 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits Ě 1 Yes 2 X No items 23a or 28a-f show Maryland Cecil North East with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 140 Mahogany Drive 21901 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, must be Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc hours after death 1 X Never Married 2 Married 1 X Yes 'n Yes 2 X No specify Yes, Give Year Specify: White Widowed 4 Divorced "natural". the Medical Examiner 1981-2001 \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 hent of Health and Mental Hygiene ant: If item 27 is marked other than " Baltimore, MD 21215-0036 Staff Sargeant U.S. Army 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Philip Spruyt Eleanor Bezer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aztec Court, 20 Toms River, New Jersey 08757 Philip Spruyt / Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) November 1 X Burial 2 Cremation 3 Removal from State Department of Important: 1 Jersey Veteran's 2006 Donation 5 Other Specify Arneytown, New Jersey 0.0 22. Name and Address of Facility Crouch Funeral Home 21. Signature of Funeral Service Licenses South Main Street, North East, Maryland21901 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failure. List only one cause on each line /Medical Death Cardiomegaly Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical XUNPENDED **AMENDED** PII.27.perME.g861.11/14/06 TT Box 68760, IF FEMALE 23c. If ves. outcome of pregnan phy: 23d. Date of delivery 23b. Was decedent pregnant in the Month Year Fetal death Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. ð Yes 2 No 3 Probably 4 Unknown Diabetes Mellitus Completed 24a Was an 24b Were autopsy findings available autopsy prior to completion of cause of has perform death? Yes 2 1 V Yes No certificate 25. Was case referred to medica Hospital or Attending Physician: 26. Place of Death (Check only one Be Other<sub>4</sub> examiner? Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other Scene 1 V Yes Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: 1 X Natural after death Pending 1 Yes 2 No by the Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building etc. 28f. Location (Street and Number or Rural Route Number City 6 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Within 2 To the 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. October 29, 2006 30 Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Registrar's Signature

State

Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 19, Oct. 2006 7:10A Richard Twyman Jr Frank /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville Montgomery Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Mar. 21, 1934 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days **XXX** 2□ F 214-30-1290 72 Maryland Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City. Town or Location 10a. State 28e-f ehow the Medical Examiner count be notified at Rockville 1⊠Yes 2 No MD Montgomery Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 902 North Stonestreet Ave 20850 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status within 72 hours after 1 Never Married 2 Married ò Specify: Black Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: δ 3 Widowed 4 Divorced 'natural' Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Private Stone Mason 11th pelij 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Importent: If them 27 is marked other treumatic event size. 17. Father's Name (First, Middle, Last) Be Mary Wilson Frank R. Twyman Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904 19a. Informant's Name/Relationship (Type, Print) 601 East Randolph Rd #314 Silver Spring,MD Thelma Twyman- Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State 10/27/06 Ash Memorial Cem Sandy Spring, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home, PA Signature of Funeral Service Licens 246 N. Washington St Rockville, MD20850 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Metabolic Acidosis Days /Medical Due to (or as a consequence of): Examiner Metastatic Prostate Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician by Physician/Medical the attending for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ate hes been signed by the a page 2 should be detached to Division of Vital Records, P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 1 Yes 2X No : After this certification, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ X90 1 X Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours efter death To the Funeral Director: compietely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral E 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tiffe of certifier 29c. License number 29d. Date signed (Month, Day, Year) D64115 October 19, 2006 Name and address of Derson who completed cause of death (Item 23a) (Type, Print)

Kelly W. Mercer, MD 6001 Medical Center Dr Rockville, MD 20850 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 Registrar

			1 - For State Registrar	State of Mary		artment of H		d Mental Hyg	iene .g. Ng 2 0 0 6	35613
ľ			Decedent's Name (First, Middle, Last)					2. Date of Dear		3. Time of Death
	Physici /Medic		Agnes Elizabeth	Tellus				October	14, 200	
	Examin		4a. Facility Name (If not institution, give stre	et and number)		4b. City, Town, or	r Location of D	eath	4c. County of De	eath
			Potomac Valley Nurs		1 - 1 - 1 - 1	Rockvi		Hrs. I a Date of Birds	Montgo	
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Birth (Month, Day) Dec. 09	Year) 1927 N	lirthplace (State or Foreign Country) EW York
	Director		Usual Residence of Decedent		70			Dec. 09	, 1927 N	ew TOTK
	yłand 10w		10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits
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	or 28	Directo	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	-
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	er deg	Funeral	T. Wasta States	Was Decedent Ever Amed Forces?	in U.S. 13. \	Was Decedent of H If Yes, specify Cuba	lispanic Origin? an, Mexican, Pi	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ar Black, Wi	nerican Indian, nite, etc.
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Ş	2 hou	ed	15. Decedent's Educat	ion	16a. Deced	dent's Usual Occup	ation		16b. Kind of Busines	
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<u>a</u>	and rand		19a. Informant's Name/Relationship (Type			•		r Rural Route Number	-	
ر ق	1 and Health Sm 27 ther t		William Tellus / So		/ZI Fa		Drive		20c. Location - City	e, MD 20850
وّ	Pages nent of I int: If ite		1 ☐ Burial 2 🛱 Cremation 3 ☐ Rem	oval from State	cemetery, cren	natory or other plac				ia, Virginia
altimore,			' 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	ļī.	-					
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īa	ician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?					Death (Check only on		
5	Physic this c	<sup>2</sup>	1 Yes 22 No		2 ER/Outpatien			ng Home 5 Reside		pecify)
ב	ding P. After funera	ion	Testfatarar o Li origing	28a. Date of Injury (Month, Day Yea	ar) 28b. Time of Injury	Wor	yat k? Yes 2 □ No	28d. Describe fic	w injury occurred	
<u>S</u>	or Attendi after death. Director: A in by the fu	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury -	At home, farm, str			28f. Location (St	reet and Number or	Rural Route Number,
Division	after of Direction by	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S	pecify)	,,,		City or Town	, State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier (Check only one)  1  Certifying Physic 2  Medical Examine one)					lace, and due to the ca		
	o the	Mec	29b. Signature and ritle of certifier	A COLUMN		29c. Licens	e number	2	9d. Date signed (Mo	nth, Day, Year)
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	1		30. Name and address of person who com			Print)			1	
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		For State Registrar	State of Marylan		artment of H			giene Reg. No. 006	5 35614
Physic	ian	Decedent's Name (First, Middle, Last)     Sheng Lin Tang					2. Date of De Month	Day Ye	n M
/Medi Exami	cal	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of De	Octobe	er 23, 200 4c. County of E	0 1:13
Exami	ilei	Holy Cross Hospit	al		Silve	r Spri	ng	Mon	tgomery
Funeral		5. Social Security Number 6. Sex		last birthday) 92Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	in. 8. Date of Bir (Month, Da Feb. 20	th 9. ay, Year) 1914 C	Birthplace (State or Foreign Country) hina
Director		Usual Residence of Decedent							
nylanc how		10a. State 10b. County	10c. City	y, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes — No
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with the	ā	10e. Street and Number	Ctooot		10f. Zip Code	NO. E			t Country :
eath me 23	eral	10711 Shaftsbuy	12. Was Decedent Ever in U.	S. 13.	Was Decedent of Hi If Yes, specify Cuba	9895 spanic Origin?	(Specify Yes or No	USA 0- 14. Race - /	American Indian,
ire, Maryland 21215-0036 s. 1 and 2 should be filed within 72 hours after death with the Maryland if Heelth and Mental Hyglene. Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Examinar must be notified at	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		If Yes, specify Cubai 1 □ Yes 2 No	n, Mexican, Pu Specify:	erto Rican, etc.)	Specif S	Vhite, etc. ian
21215-0036 de within 72 hours afregiene. er then "naturel", or the Maxicel Etenin.	ted	15. Decedent's Edu	cation		dent's Usual Occupa		working	16b. Kind of Busin	ess/Industry
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Heelt Heelt Tem 2	1	Amy Peng/ Daughte 20a. Method of Disposition	20b. P	lace of Dispo	SNAITS DU sition (Name of matory or other place		Date	ngton, MD 20c. Location - City	
Pages lent of nt: if t	1	1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State		manory of ourse place Memorial F	1 001	tober 25, 2006	Olney, M	arvland
Baltimore, Neparation Permit. Pages 1 and Department of Heelth Important: if them 27 any injury or other 1 once.		21. Signature of Funeral Service Licens	ee					1 Home In	
		23a. Part 1. Enter the disease, or compleshock, or heart failure. List only of	ications that coused the death	n. Do not ent	er the mode of dying	g, such as card	fiac or respiratory a	rrest,	Approximate Interval Between
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2 2 2	by Ph	Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did 1	tobacco use contribu	te to the cause of death?
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	tion: T	27. Manner of Death  12 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work	vat ⟨? Yes 2 □ No	28d. Describe	how injury occurred	
	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		reet, factory, office			(Street and Number of wn, State)	or Rural Route Number,
Dir To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C		sician: To the best of my kno ner: On the basis of examina and manner stated.						
To the h within 2 To the I	Me	29b. Signature and little of certifier	001		29c. License	number		29d. Date signed (A	fonth, Day, Year)
3		> WW Och	uly		D625	20		October 2	3, 2006
		30. Name and address of person who of Maria D'Arbela, M			Print)		Spring, M	4D 20910	
St Regis	ate trar	31. Date filed (Month, Day, Year) OCT 2 5 20	32. Registrar's Signa	tyre	anti				

UNK UNK Clarence J. Tyson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day October 19, 2006 2257 hrs Medical Examiner Clarence Jerome Tyson, Jr. 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Baltimore 3900 block Falls Road If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months Days Hours Director Country) MD 1 XM 2 F 72 Vrs 5/2/1934 215-28-3028 Usual Residence of Decedent 10a. State 10b County Oc City Town or Location 10d Inside City Limits 1 X Yes 2 No Baltimore MD 10g Citizen of What Country? 10f. Zip Code 10e Street and Number ā United States 1515 West 36th Street 21211 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, 11 Marital Status 12 Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 X Married Armed Forces? Never Married Yes If Yes, Give Year 1 Yes 2X No specify: Widowed Divorced Specify: White <u>م</u> 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry of Health and Mental Hygiene.
If item 27 is marked other than "natur:
ther tranmatic event, the Medical Exami 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 lent of Health and Mental Hygiene.

ant: If item 27 is marked other than " Baltimore, MD 21215-0036 Farm Hand Farming 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Clarence Jerome Tyson, Sr Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1024 Highfield Dr., Hampstead, MD 21074 Wife Mary Frances Tyson 20a. Method of Disposition

1 Burial 2 Cremation 3 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place)
Carroll Cremation 10/24/2006 Removal from State Hampstead, MD partment c portant: ury or oth Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Eline Funeral Home, 934 S. Main Street M00723 M00723 Hampstead MD 21074

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and sician/Medical UNPENDED AMENDED physician the burial -Box 68760 IF FEMALE. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth Fetal death Year nast 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown a Unknown Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. ģ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? page ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) To the Hospital or Attending Physician: Be Other<sub>4</sub> examiner? Hospital: 1 Inpatient 2 Nursing Home 5 Residence 6 ✓ Other: Scene ER/Outpatient 3 DOA 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day Year) Oct 19, 2006 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred 27. Manner of Death Certification: s after dea.

"al Director: Af Pedestrian struck by auto Natural 2249 hrs 1 Yes 2 V No Pending 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State determined (Specify) Local Street 3900 block Falls Road, Baltimore, MD Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started **Medical** 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c License number October 20, 2006 OCME 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32/Registrar's Signature State OCT 2 4 2006 Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician AUDREY** VANCE CLAIRE October 22, 200612:40p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WORCESTER BERLIN NURSING & REHAB. CENTER BERLIN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1 ☐ M 2 🗓 F 046-18-5802 81 SEPT. 29, 1925 CONNECTICUT Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other then "naturel", or iteme 23e or 28e-f sho other traumatic event, the Madical Examiner must be nutified at 1 ☐ Yes 2 No Directo DELAWARE SUSSEX SELBYVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 68 MALLARD DRIVE 19975 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Heelth and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or iter eny injury or other traumatic event, the Medical Examina-1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Vance, Audrey Baltimore, Maryland 21215-0036 Specify: WHITE Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) WAITRESS FOOD SERVICE 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be BENJAMIN HORTON ANN **SCHOTANUS** ပ္ SEARLES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7 KENT PLACE, COSCOB, CONN. 06807 CHERYL S. DOEBERL/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State CREMATORY OF DELMARVA 10/24/06 4 ☐ Donation 5 ☐ Other (Specify) DELMAR, DELAWARE 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 MO 1343 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Betw Immediate Cause (Final **Physician** car disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant all time of death 5 Other (specify) signed by the a 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death buy or resulting in the underwing cause given in Part I Completed by Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available pnor to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has birector, page 2 s ormed? 20 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification; 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours To the Funerei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and titte of certain 29c. License number 28569 outel Halway leted cause of death (Item 23a) (Type, Print) Wholer State 5 2006 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 35617

		ĺ	1 - State Registrar			Cen	tificate of	Death		F	Reg. No			
	Physici	an	Decedent's Name (First, Middle, Last Virginia Iris W.)		zon					2. Date of Dea Month	Da		3. Time of Death	
	/Medic						# 02 T	. 1	-10	October			4:50 A M	_
1	Examin	er	4a. Facility Name (If not institution, given Ginger Cove Heal				4b. City, Town, o				40	County of Death		
			5. Social Security Number 6. S		je (In yrs. last bin	thday)	If Under 1 Year	napo		8. Date of Birt	h		Arundel	_
	Funeral Director			M 20 F		Yrs.	Months Days	Hours	Min.	(Month, Da)	y, Year)	l Mary	place (State or Foreign Intry)	
			Usual Residence of Decedent	A						MOV.II,	171.	ı ııcıı y	Tand	
	yland		10a. State 10b. County		10c. City, Town	n or Loc	ation						10d. Inside City Limits	
	Mar	ţċ	Maryland Anne Aru	ındel		A	nnapolis						1 □ Yes 2√XNo	
	1 28 ro	Director	10e. Street and Number				10f. Zip Code				_	izen of What Co		
	th will	<u>a</u>	4000 River Cresce	ent Drive			2	1401			1	Jnited S	tates	
	des m	Funeral	11. Marital Status	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🔏	Ever in U.S.	13. W	as Decedent of H Yes, specify Cubi	fispanic Or an, Mexica	igin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)		<ol> <li>Race - Amer</li> <li>Black, White</li> </ol>		
Maryland 21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Items 23a or 28s-f show say halpry or other traumatic event, ir a Medical Examiner must be indifficat at ance.	þ	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No	1	☐ Yes 2☐ No	Specify:	:			Specify:	White	
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and	be fill d oth	Be	17. Father's Name (First, Middle, Last)	n Howard W	allor			18. Motri		s Messi		i Sumame)		
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ā N	12 st h and 7 is n traun		John N. Wilson,				g Address <i>(Street</i> River Cr						land 21401	
	1 en Heal Iem 2		20a. Method of Disposition	, nabb	20b. Place of	Dispos	sition (Name of			Date		ocation - City or		-
ο̈́	ages ant of nt: if if y or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Specif			, .	ff Cemet		10/2	6/06	Anna	apolis.	Maryland	
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ä	Depermine on the concession of		John	EIR	lle	14	7 Duke o	f Glo	uces	ter St.	,Anı	napolis,	MD 21401	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that ceuse	d the death. Do r	not ente	r the mode of dyir	ng, such as	cardiac	or respiratory ar	rest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition			ic.	Cereb	1 o Va	2Cu	dan Di	SPO	101	Onset and Death	
	/Medical		resulting in death)	Due to (or as	a consequence	of):		( -			-	77	10(00(1)-	-
	Examiner		Sequentially list conditions.	· Cana	homy	of	rathy						years	_
-	pe sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence	bl): [								
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687	ficate phys s the	/Medical		a. Chic									Jians	_
ŏ			IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth	ol pregnancy 2 Fetal death	3 🗔	Ectopic pregnanc	у				23d. Date of deli	very Day Year	
P.O. B	The law requires that the death ate has been signed by the atte bage 2 should be detached for a	Physician	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of death	5 🗆	Other (specify) _					WORK	Day Tour	
	s that ned b e deta	by PI	Part II. Other significant conditions of	contributing to death t	out not resulting in	n the un	derlying cause giv	en in Part	I.	23e. Did to	obacco	use contribute to	the cause of death?	
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Division of Vital Records,	has been	Completed								24a. Was		24b. Were au	topsy findings available completion of cause of	
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isi	death death stor: , the f	icat	Accident investigation 3 ☐ Suicide 6 ☐ Could not b	e 38a Blace of In	jury - At home, fa	rm etro		103 2	1140	28f. Location /5	Street au	nd Number or Ru	ral Route Number,	_
<u>≥</u>	il or Attend after death Director; /	Certification:	4 ☐ Homicide determined		tc. (Specify)	, 500	est, ractory, office			City or Tox			i de la constanta de la consta	
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifying Pt (Check only 2 Medical Example)	nysician: To the best miner: On the basis of	of examination an	e, death	occurred at the trestigation, in my o	me, date a	nd place, ath occur	and due to the red at the time,	cause(s	) and manner as d place, and due	stated. to the cause(s)	_
	ithin 2 o the	Med	29b. Signature and title pl certifier	and manner si	iaitu.		29c. Licens	se number			29d. Da	ite signed (Monti	, Qay, Year)	
	or with the control of the control o		K Kakisk	han	0/01	M	D	D2	01		1	10/23	106	
			30. Name and address of person who	completed cause of	death (Item 23a)	(Type, F			-					-
-			Dr. Rakesh Arora				Lane Bo	wie.	Mary	land 20	715			
i	Sta Regist		31. Date filed (Month, Day, Year)	32 Regist	rar's Signature	1	and o	,						
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		•	For State Registrar	State of Ma	•	epartmer <i>Certificat</i>			_	gienę Reg. Nd	2006	35618
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	/Medic Examin		4a. Facility Name (If not institution, give		allieid		Town, or Lo	ocation of Death			County of Deatl	h
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	aryland show	,	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
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ş	2 hou	ted	15. Decedent's Ed	ducation	16a.	Decedent's Usu	al Occupation	on ing most of worki	ina	16b. K	ind of Business/	Industry
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2	Hygie Hygie other ti		12 17. Father's Name (First, Middle, Last)	)		raime		8. Mother's Name	(First, Middle,			
jan	e d la b	To Be	Raymond L. Warf	ield, Sr.				Bessie	M. A	11nı	utt	
Maryland 21215-0036	and 2 should salth and Men n 27 le marke ler traumatic		19a. Informant's Name/Relationship ( Dorothy E. Warfie			. Mailing Addres 3251 Dam	S (Street and ASCUS	Road, G	al Route Numbers	or, City of bur (	or Town, State, 2 g, Mary]	Tip Code) Land 20882
Jore,	- I i		20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐		20b. Place of cemeter	Disposition (Nary, crematory or	me of other place)	ry 10/3	Oate		ocation - City or	Town, State
Baltimore,	permit. Page Department of Importent: If eny injury or once.		4 □Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer		Mt. Le	22 Name a Moles	Morth	of Facility William	s P.A.,	, Fu	neral Ho	ome
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	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	10.		20 0. 0,9,		, , , , ,		A Control	Interval Between Onset and Death
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s, P.O.	res that the designed by the a	by Physicia	9 ☐ Unknown  Part II. Other significant conditions of		ut not resulting i	n the underlying	cause given	in Part I.	23e. Did t	obacco		the cause of death?
ord	w require been sig should b	ted	Renal Fo	vilure.					10'	Yes 2	-,	obably 4 Munknown
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Division of	= B = C	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju- building, etc	ury - At home, fa c. (Specify)	arm, street, facto	ry, office		28f. Location (. City or To			ural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one) 12 Certifying Pl	miner: On the basis of and manner sta	examination ar	death documend/or investigation	et the time n, in my opin	date and place, nion, death occur	and due to the red at the time,	date an	) and manner as d place, and due	to the cause(s)
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)	n			Am i	PHYSIC	IAN	63	168		10	125/	06
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			1 - For State Registrar	State of Ma	arylan		artmer rtificat			ind Me		giene Reg. No.	7005	3	5619
	79.		1. Decedent's Name (First, Middle, Last	)	,	11.					2. Date of Dea Month	ath Day	/ Year	3. 1	Time of Death
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	Examin		4a. Facility Name (If not institution, give	street and number)	11		4b. City	Town, or	Location o	f Death			County of Dea	th	
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	Funeral		5. Social Security Number 6. Se	x 7. Ag □M 2X F		ast birthday) Yrs.	If Unde Months	r 1 Year Days	Hours	Min.	<ol><li>Date of Birt (Month, Da)</li></ol>	/, Year)	T C	ountry)	State or Foreign
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	ma 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U.:	S. 13.	Was Dece			in? (Spec	cify Yes or No-		14. Race - Am		dian,
9	or Ite		1 ☐ Never Married 2 🔀 Married	Amed Forces? 1 ☐ Yes 2 ☑ If Yes, Give	No		1 ⊡ Yes		Specify:	, FDeito n	rican, etc.)		Black, Whi Specify:	ie, eic.	
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7	and Ment le marke sumatic	ဥ	19a. Informant's Name/Relationship (T		, sk.	19b. Mailir	na Addres	s (Street a	nd Numbe				r Town, State,	Zip Code	
Maryland	V 40 -		DR. RALPH C. GOMES -								ILLE, MA			•	
ē,	s 1 and 2 f Heelth Item 27		20a. Method of Disposition		20b. Pi	lace of Dispo	sition (Na	me of	1		ate		ocation - City or	Town, S	tate
9		i	1 ☐ Burial 2 ☐ Cremation 3 🔯 4 ☐ Donation 5 ☐ Other (Specify		-	. WOOTEN	-			10/27	/2006	LOVE	LADY, TE	XAS	
altimore,	Depertment of Important of Important of Important: If eny injury or once.		21. Signature of Funeral Service Licens			22	. Name a	nd Addres	s of Facility	,		LOTE	Land 1, IL		
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of Vital Records, P.	gned be de	by	Part II. Other significant conditions co	ntributing to death b	ut not resu	ılting in the u	nderlying (	cause give	n in Part I.		23e. Did to		use contribute to	o the cau robably	se of death?
Ö	w require been si should	Completed									24a. Was	an	24b. Were a	utopsy fir	ndings available
Re	The re h	m o	•								autop perfor	med?	death?		on of cause of
tal	riclan: 1 certifical rector, p	0	25. Was case referred to medical						26. Place	of Death	Check only o	2DONo	10.	201	
$\geq$	Physician: this certific ral director,	ToB	examiner? 1 XYes 2 ☐ No	Hospital:	ent 2	ER/Outpatier	nt 3□ D	OA Othe	•				6 □Other (Spe	icify)	
	Ilng After		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ry y Ye <i>ar)</i>	28b. Time of Injury	м	28c. Injury Work 1 🗆 Y	at ? 'es 2 □ N		8d. Describe h	ow injur	y occurred		
Division	Hospitet or Attence     A hours after dealt     Funeral Director:     etely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuding, etc.			eet, factor	y, office		2	8f. Location (S City or Tow		d Number or R )	ur <b>ai</b> Rout	le Number,
	To the Hospitet or At within 24 hours after d To the Funeral Direct completely filled in by	edicai		sician: To the best iner: On the basis of and manner sta	examinat										ause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier					c. License		( )			e signed (Mon		_
	12)		30. Name and address of person who co	reckon	mo	Dm	= 1	) 0	043	18	0 - "	901		20	006
	V ~			ompleted cause of d	eath (Item	23a) (Type,	Print)	2121	m.	611	a Po		Dr		
	a make to		JRA N BRET	H FY J	no	UME	5	1100	r 5p	117	9 m.	0	2090	2_	
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 6 20	06 32 Registra	ar s Signat	OME	التالما								

		For	State of Ma		/ Depa	artment of H	lealth and	•	ygiene		250	20
		1 - Stata Registrar			Cei	tificate of	Death	10011		2006	356	
Physici	ian	Decedent's Name (First, Middle, Last						2. Date of Month	Da			
/Media	cal	John Prentice W  4a. Facility Name (If not institution, give	agner			4b. City, Town, o	r Location of Dec	Octob		, 2006 County of Dea		a <sup>M</sup>
Examir	ner	Potomac Valley Nu		<b>a</b>		Rockv		auı		Montgon		
Funeral		5. Social Security Number 6. Se		(In yrs. las	t birthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of				or Foreign
Director		579-36-5319	§M 2□F	80	Yrs.	Months Days	Hours Mi	n. B. Date of (Month, Jan.	10, 1	926 01	rthplace (State of country) Lahoma	
pu		Usuel Residence of Decedent  10a. State 10b. County		10c. City, T	Faura 1 1	antina					10d. Inside Ci	ity Limite
shov	2			•		Cation					1 XYes	
the N 28a-f	Director	Maryland Montgom  10e. Street and Number	iery	ьесі	nesda	10f. Zip Code			10g, Cit	izen of What C	ountry?	
With Ba or	ā	10112 Edward Aven	110			208	14			ited St		
death ms 2;	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. \	Was Decedent of H		(Specify Yes or	_1	14. Race - Am	erican Indian,	
or its		1 ☐ Never Married 2 Narried	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	0		1 Tes, specify Cub. 1 □ Yes 2 점 No		eito Aican, etc.)		Black, Wh	ite, etc.	
Mary iditio Z I Z I 3-0030 d 2 should be filed within 72 hours atter death with the Maryland th and Mental Hyglene. It is marked other than "netural", or items 23e or 28e-f show traumatic event, the M. disal Extended.	d by	3 Widowed 4 Divorced	Year or Dates:							Wh	ite	
72 t	ete	15. Decedent's Edu (Specify only highest grad	ucation de completed)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of w	vorking	16b. K	ind of Busines	s/Industry	
withir with the man	Ę	Elementary/Secondary (0-12)	College (1-4or 5+	+)		acher	-/		Pu	blic So	chool	
uld be filed w Mental Hygier Irked other th	Be Completed	17. Father's Name (First, Middle, Last)					18. Mother's N	ame (First, Mide				
lic eve	To B	John Clifford W	agner				Mario	n Loui	se P	rentice	9	
Marytal d 2 should b th and Ment th and Ment 27 is marked traumatic e	-	19a. Informant's Name/Relationship (T)	ype, Print)		19b. Mailir	ng Address (Street	and Number or i	Rural Route Nui	nber, City o	or Town, State,	Zip Code)	
E, ING 1 and 2 Health a tem 27 is		Polly S. Wagner /	Spouse			Homecres						906
of He		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐I	Removal from State	1		sition (Name of natory or other pla	1	Date		ocation - City o		
All IIIOCE, mil. Pages 1 ar partment of Hea portant: if Item; y injury or othe		'4 □ Donation 5 □ Other (Specify,		Ft.		oln Crema			_			.and
Dartimore, IV permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr once.		21. Signature of Funeral Service Licens	600		511	Name and Addre	ss of Facility oute Fun	eral an	d Cre	mation	Center	
		23a, Part, Enter the disease, or comp	lications that caused	the death.		40 Rockv				, Mary	and 208 Approximate Interval Bet	
		23a. Part , Enter the disease, or comp shock, or heart failure. Ust only o Immediate Cause (Final	one cause on each lin	θ.		,	J.	,			Interval Bet Onset and (	ween Death
Physician /Medical	ı	disease or condition resulting in death)	a. Pneumon:		nce of):							
Examiner			Failure									
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a									
acuted ind transi	Examiner	that initiated events resulting in death) Last	c. Due to (or as a									
rou, e be executed /sician and e burial-transit		resulting in country basis	Due to (or as a	i consequer	nce or):							
• œ × œ	dical		d									
BOX 08/ leath certificate attending phy:	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			-				23d. Date of de	elivery	
death certificat death certificat e attending ph	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 3 4 ☐ Pregnant at			Ectopic pregnanc Other (specify) _	/ 		-	Month	Day *	Year
at the de de by the fetached	hys	9 Unknown	9□ Unknown						i i			_
cords, F.C. wrequires that the deben signed by the should be detached	by	Part II. Other significant conditions co	entributing to death bu	t not resulti	ng in the u	nderlying cause giv	en in Part I.				to the cause of d	
Ord requir sen s rould	ted							-		Ţ	Probably 4 🗀	
The law The has b	Completed							24a. W	as an topsy nformed?	24b. Were a prior to death?	utopsy findings completion of c	available ause of
r: The			<del></del>					1 □ Ye	2 ₽ No			
VIII Siciar certif	) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 🗆 Inpatier	a 🗆 🗆	2/Outrotion	nt 3□ DOA Ott		eath <i>(Check on</i> Home 5□R		6 DOther /Sa	acifu)	
OF B Phy er this eral d	n: To	27. Manner of Death	28a. Date of Injury (Month, Day)		8b. Time of		v at	28d. Descrit	_		bony)	
nding ath. r: Afte	atio	1 Natural 5 Pending 2 Accident investigation		( Gar)	Injury		Yes 2 ☐ No					
JIVISION OF VITAL RECORDS, to Attending Physician: The law requires that cleath.  Director: After this certificate has been signed in by the funeral director, page 2 should be a	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	ry - At hom. . (Specify)	e, farm, str	eet, factory, office			n (Street ar Town, State		Rural Route Num	iber,
Lisatt rai Di												
DIVISION OF VITAI HER To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical		vsicien: To the best of iner: On the basis of and manner sta	examination								;)
o the ithin 2 o the omple	Mec	29b. Signature and title of certifier	Circ mailloi sta	1		29c. Licens	se number		29d. Da	te signed (Mor	nth, Day, Year)	
10		) \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	1 has	1		нооч	51280		10	/20/200	16	
10		30. Name and address of person who o	completed cause of de	att (Item 2	3a) (Type,				1.0	, _5, 200	<u> </u>	
		Anushiravan Dadga	ar, D.O.	971.	5 Med	ical Cen	ter Driv	re #201;	Rock	ville,	MD 2085	0
	ate	31. Date filed (Month, Day, Year)	32. degistra	ır's Signatur	re	ali)						
Regist	ırai	OCT 2 6 2	A MARINE	1 55	100							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene o o c

			State of Maryland	$C\epsilon$	ertificate of I	Death		"ZUU6	35621
			Decedent's Name (First, Middle, Last)		7,1,1100.10 07.1		2. Date of Death		3. Time of Death
=	Physici		FRANCES LORRAINE W.A	GA	FR		OCTOBER 1	Day Year	6 2020
No.	/Medic Examin		4a Facility Name (If not institution, give street and number)		4	b. City, Town, or Lo		4c. County of De	eath
1			BROOKE GROVE REHABILITATION AND A	ucesin	UG (ENTER	SAND	1 Sterr		STGOMERY
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la:	st birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. E	Birthplace (State or Foreign Country)
	Director		577-09-6162 91  Usual Residence of Decedent	115.			Oct. 3,	1915   Wa	shington, DC
	ow #			Town or L	_ocation				10d. Inside City Limits
	Many	ţo	Maryland Montgomery Sil	ver !	Spring				1 ☐ Yes 21 No
	or 28	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What	Country?
	th wil	aj C	203 Crestmoor Circle		20901			U.S.A.	
	r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces?	. 13.	<ul> <li>Was Decedent of H</li> <li>If Yes, specify Cuba</li> </ul>	ispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ai Black, W	merican Indian, hite, etc.
)20	be filed within 72 hours after death with the Marylend ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No If Yes, Give 3 🖾 Widowed 4 ☐ Divorced Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify: \[ \]	White
Maryland 21215-0020	2 hou	ted		16a. Dece	edent's Usual Occup	ation	10	6b. Kind of Busine:	ss/Industry
218	within 7 ene. than "n	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	life.	re kind of work done o DO NOT use retired	during most of work"	'g		
21	filed wi Hygien other th	Cou	12th	Нс	omemaker		/=	Domestic	
gue	be fill d oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name		•	.L
3	should be and Mental s marked o	ဥ	Frank Hartman Rowzee  19a. Informant's Name/Relationship (Type, Print)	10h Mai	ling Address (Street	Christin			
Ma	ith and 17 is r		Joseph M. Wagner/Son		6 Kent Roa				
ē,	item 2		20a Method of Disposition 20b Pla	ace of Disp	position (Name of ematory or other place		Date 2	Oc. Location - City	
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 is marke any injury or other traumatic once.		1 🖾 Burial 2 □ Cremation 3 □ Hemoval from State		11 Cemetei	. I I	0/27 006 s	ui+land	Maryland
alti	mit. I sartm sortar inju		21. Signature of Funeral Service Licensee	2	22. Name and Addres	ss of Facility			Haryrand
ä	Depa impo any is		N- A K		IINES-RINA 1800 New				ng, MD 20904
			23a. Part1. Enter the disease, or complications that caused the death. shock, or his distribute. List only one cause on each line.	Do not er	nter the mode of dyin	g, such as cardiac o	respiratory arres	st,	Approximate Interval Between
	Physician		Shoot, drip Transe. Elst only one sease or each line.						Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. PEWIC MALI	1CTN	ANCY TY	PE UNK	SOWN		MONTHS
	L Adminies	-	resulting in death)  Due to (or a	as a conse	equence of):				
	ted nsit	edical Examiner	b		0				
<b>,</b>	tificate be executed og physician end as the buriel-transit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	as a conse	equence or):				
68760,	ysicia e bur	cai	that initiated events   Due to (or a	as a conse	equence of);				
	ng ph as th	Med	resulting in death) Last						
Box	th certendir	an/	<b>d</b>						
E	e dea the at hed fo	Physician/M	Part II. Other significant conditions contributing to death but not result	ling in the	underlying cause giv	en in Part I.	23b. Did tob	acco use contribu	ite to the cause of death?
P.0.	law requires that the death certificate be executed as been signed by the attending physician end a 2 should be detached for use as the buriel-transit	F.	COPONARY ARTERY DIC	EA	SE		1 🗆 Yes	3 2 ⊠ No 3 □	Probably 4 ☐ Unknown
gp.	sign Id be	Completed by					24a. Was an		o. Were autopsy findings
Ö	v req	lete	<u> </u>				perform	ed?	available prior to completion of cause of death?
Re	The law ete has page 2	E O					1 ☐ Yes	2 No	1 ☐ Yes 2 ☐ No
ta	i <b>cian</b> : The certificete rector, pag	BeC	25. Was case referred to medical			26. Place of Death	(Check only one,		
<b>&gt;</b>	Attending Physician: In death. ector: After this certific by the funeral director,	10 E	examiner? 1   Yes   2   No   Hospital: 1   Inpatient   2   El	R/Outpatie	ent 3 DOA Oth	er: 4 Nursing Hon	ne 5 🗆 Residen	ce 6 □Other (S)	pecify)
0	ng Ph fter th neral	Ë	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 2	28b. Time ( Injury	Worl		8d. Describe how	v injury occurred	
sio	tendil leath. tor: A the fu	cati	2 Accident investigation			Yes 2□No	Of Location /Ctro	ot and Number or	Rural Route Number,
Division of Vital Records,	if or Attending P after death. I Director: After t d in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could Not be determined 28e. Place of Injury - At hom building, etc. (Specify)	ie, farm, s	treet, factory, office	2	City or Town,		nurar noute Number,
	Hospital 24 hours 8 Funeral I stely filled		29a. Certifier 12 Certifying Physician: To the best of my knowledge.	ledge, dea	th occurred at the tin	ne, date and place, a	nd due to the ceu	ise(s) and manner	as stated.
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificete hat completely filled in by the funeral director, page	edical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.						
	To the within 2 To the comple	Ň	29b. Signature and title of certifier		29c. License			d. Date signed (Mo	
	1		MM.D. ATTENDING PHY	15161	AN DY	12046	00	JOSER Z	5,2006
	13		30. Name and address of person who completed cause of death (Item 2)  GRACE BROOKE HUFFMAN, M-D. 1	23a) (Type	e, Print)	0 0		20	200
			(RACE BROKE (TVFMAN, M-D, 1) 31. Date filed (Month, Day, Year) 32. Registrar's Signaly	8100	SLADE SCIT	oci KOAD S	ANDY SF	KINGIMA	HEYLAND LOXO
	Sta Registr		OCT 2 6 2006	15	mente				

		For State	State of M	laryland /	Department of I		ental Hygie	2006	35622
		Registrar			Certificate of		Reg 2. Date of Death	J. No.	
Phys	ician	Decedent's Name (First, Middle,					Month	Day Year	3. Time of Death
	dical			HITTIN			ctober	20, 200	
Exan	niner	4a. Facility Name (If not institution,	give street and number)	)		or Location of Death		4c. County of Dea	th
			anor		pinthday) If Under 1 Year	If Under 24 Hrs.		Somer	set
Funer			5. Sex 7. Ag 1 ☑ M 2 ☐ F	ge (In yrs. last b	Yrs. Months Days	Hours Min.	B. Date of Birth (Month, Day, )	'ear) 9. Bin	thplace (State or Foreign buntry)
Directo	or	221-14-4339		82	113.		larch 8,	1924 Mary	yland
and **		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Location				10d. Inside City Limits
Aaryl:	ō		a a a t		Cri	sfield			1 ☐ Yes 2 ☐XNo
the N	Director	Maryland Some	LSEL		10f. Zip Code	.brieid	100	. Citizen of What Co	ountry?
with	ā				1000	21817		USA	ŕ
eath	Funeral	3199 Boone Road	12. Was Decedent	Ever in U.S.	13. Was Decedent of I		ifv Yes or No-	14. Race - Ame	erican Indian,
ter d	Ë	1 ☐ Never Married 2 ☑ Marrie	Armed Forces	?	If Yes, specify Cub	lispanic Origin? (Spec an, Mexican, Puerto Ri	ican, etc.)	Black, Whit	e, etc.
urs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:		Specify: W	nite
IL I I I I I I I I I I I I I I I I I I		15. Decedent's	Education	16	a. Decedent's Usual Occu	pation	16	b. Kind of Business	/Industry
7 nin 7.	pie	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	5+)	(Give kind of work done life. DO NOT use retire	during most or working d)		Grain and	Poultry
u z Iz filed withi Hygiene. other then	Completed	12	00110g0 (1 401	0.7	Farmer			arming	
othe flet,	0	17. Father's Name (First, Middle, La	ast)			18. Mother's Name (			
should be not Mental or marked or marked or	To B	Austin L. Whitt:	ington			Hazel E	sther Tu	111	
2 shot and h is ma		19a. Informant's Name/Relationshi	p (Type, Print)		b. Mailing Address (Street			-	Zip Code)
ite, INIAI yidalid ZIZIOJOOO s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Menlaul hygiene. It may be marked other than "natural", or Items 28a or 28a-1 show other traumatic event, the Michigal Examinar must be inclifted at		Deborah L. Whit	tington (Wi	fe)	3199 Boone F	oad - Cris	field, N	4D 21817	
S = 1 g		20a. Method of Disposition		20b. Place cemet	of Disposition (Name of tery, crematory or other pla	ce) Da	te 20	c. Location - City or	Town, State
permit. Pages of Department of Himportant: If Its any injury or of		1√ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe	3 ∐Removal from State ecify)	, ,	idge Memorial P	1	4, 2006	Crisfield	d. Maryland
mit.	<u></u>	21. Signature of Funeral Service Li	censee	/L	22. Name and Addre	ss of Facility Sons Fune	ral Home		7
D P D D D D D D D D D D D D D D D D D D	Suc	Mary Beth Bi	radshaw-Pru	i++		n St Cr			7
		23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that cause	d the death. Do					Approximate Interval Between
Physicia		Immediate Cause (Final	rily one cause on each	ili io.					Onset and Death
FIIYSILIA			100,	1 mm	al PNER	M LNOW 1			DALL
/Medica		disease or condition resulting in death)		RATTO S a consequence	on free	M LNOW I			DAYS
	al	disease or condition resulting in death)	Due to (or as	s a consequence	e of):	M LNOW H			DAYS MONTHS
/Medica Examine	al er	disease or condition resulting in death)	Due to (or as		e of): //2	1 MONT 14			DAYS MONTHS
/Medica Examine	al er	disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	s a consequence	e of): //2	1 MONT 14			DAYS MONTHS
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be executed Wedician and purial-transit	Examiner	disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as Due to (or as c.	s a consequence	e of): / /2- e of):	1 MONT PA			DAYS MONTHS
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To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certification: To Be Completed by Physician/Medical Examiner	disease or condition resulting in death)  Sourchistly list and tions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant condition  ### FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  25. Was case referred to medical examiner? 1   Yes 2   No   27. Manno of Death 1   Natural   5   Pending   investiga   3   Suicide   6   Could not determined to the property one)  29b. Signature and title of certifier  30. Name and address of person we suit the past of the property of the property one)  31. Date filed (Month, Day, Year)	Due to (or as Du	s a consequence  I I I G  s a consequence  g of pregnancy  2 Fetal deal  at time of death  but not resulting  COLI SV  ient 2 ER/C  ury  ay Year)  28b  ay Year)  to f wx knowled  of examination a  tated.  I Geath (Item 23a  I Geat	e of):  // // / e of):  th 3   Ectopic pregnanc   5   Other (specify)    g in the underlying cause given    Outpatient 3   DOA    Time of	26. Place of Death (ner: 41 Nursing Homery 41 Yes 2 No 28 Me, date and place, an opinion, death occurred se number 26246	24a. Was an autopsy performed to the cauding the control of the cauding at the time, date	Month  22 No 3 Pr  24b. Were au prior to death? 1 Yes  26 Other (Speinjury occurred  set and Number or Russiae)  se (s) and manner as a and place, and due  1. Date signed (Mont)	Day Year  the cause of death?  robably 4 Unknown  utopsy findings available completion of cause of 2 No  cify)  ural Route Number,  s stated.  to the cause(s)  h. Day, Year)

DHMH 17 Rev 1/2001

Paul T. Whithngton

ORIGINAL

			For State Registrar	State of Ma	aryland / D	epartme <i>Certifica</i>	ent of H	lealth a D <i>eath</i>	ind Me		iene <sub>eg. No.</sub> 2	006	35623
			Decedent's Name (First, Middle, L.	ast)					2	2. Date of Dea	th		3. Time of Death
	Physici /Medic		Darwin J	ames	Wilson	. Sr.				Octobe	er 24	2006	5:00 AM
	Examin		4a. Facility Name (If not institution, g				ty, Town, or	Location of	Death			unty of Death	
			11110 Little Co	ve Point Ro	oad	L	usby				C	alvert	
	Funeral			Sex 7. Ag	e (In yrs. last birti	Month	ler 1 Year s Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day	Year)	Cou	lace (State or Foreign
	Director		328-20-3373 Usual Residence of Decedent		79	rs.			F	eb. 25	1927	Ill:	Lnois
	land		10a. State 10b. County		10c. City, Town	or Location						1	0d. Inside City Limits
	Mary -f sh	to	MD Calve	ert	Lusby								1 ☐ Yes 2 🕍 No
	r 28a	Director	10e. Street and Number				Zip Code			1	0g. Citizen	of What Cour	ntry?
	th with	a D	11110 Little Co	ve Point R	oad		2065	7			U	.S.A.	
	ems LEM	Funeral	11. Marital Status	12. Was Decedent Amed Forces?		13. Was Dec	cedent of Hi	ispanic Orig	in? (Speci Puerto Ri	ify Yes or No- ican, etc.)	14.	Race - Americ Black, White,	
36	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show ta Madisal Exandian man be millind at	by F.	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	If Yes, Give			2 No			,		ecity: Whit	
8	hour tural	d be	15. Decedent's	Year or Dates:	-1946	Danadant's III		ation					
Ω	In 72	olet	(Specify only highest g	rade completed)		Decedent's Us (Give kind of v life. DO NOT	work done o	durina most	of working	7	166, King (	of Business/In	austry
7	l with	Completed	Elementary/Secondary (0-12)	College (1-4or 5	Sei	cvice E	ngine	er			Comm	nunicat	ions
פ	othe	Bec	17. Father's Name (First, Middle, Las	st)				18. Mother	r's Name (	First, Middle, i	Maiden Sur	name)	1100000
<u>a</u>	Menta Menta Irked	To E	Niles Everett W	lilson				E	sther	Viole	t Sto	ne	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show appringury or other traumatic event, the Macinal Examiner must be multiled at ADGE.		19a. Informant's Name/Relationship							Route Number			
<u>~</u> `	and lealth m 27 her tr		Donna Lynn McCr	eady, Daugh				ttle (		-			4D 20657
Ore	t of H if ite or otl		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3	☐Removal from State	20b. Place of cemetery	Disposition (N v, crematory o	iame of r other plac	9)	Da	te	20c. Locati	on - City or To	own, State
Ë	t. Partmen		4 Donation 5 Other (Spec		St. Pa					2006	Princ	e Frede	erick, MD
Bal	Depermine Deperm		21. Signature of Funeral Service Lic	ensee				s of Facility			_		3.1
			23a. Part1. Enter the disease, or co	mplications that causey	the death. Do n							t Repul	Olic, MD Approximate
			shock, or heart failure. List on Immediate Cause (Final	ly one cause on each lir	ne.								Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	enic o		ICTIL	18 1	une	0/5	SHISE	(	PEARS
	Examiner	1		Due to (or as	a consequence o	nr):							
	4.	Je.	Facuartially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence o	of):						-	
	cuted	Examiner	Cause (Disease or injury that initiated events	с									
o	e exer en ar urial-t		resulting in death) Last		a consequence o	if):							
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9	death certifica ettending pt d for use as ti	Med	IF FEMALE:				-						
Вох	ath co	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic					23d.	Date of delive	ory Day Year
о -	the c	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5 Other	specify)						ou, tou
Division of Vital Records, P.O.	es that the death cert igned by the ettendin be detached for use		Part II. Other significant conditions	contributing to death b	ut not resulting in	the underlying	cause give	en in Part I.		23e. Did tol	bacco use	contribute to the	ne cause of death?
ds	uires Sign Idbe	d by	NYPERTENSI							12 Y	es 2□N	o 3 ☐ Prob	ably 4 Unknown
00	w requir been si should I	Completed								24a. Was a	n 2	th Were auto	psy findings available
Be	he lav e hes age 2									autops perforr	ned?	prior to co death?	mpletion of cause of
ta		Be C	25. Was case referred to medical	_				26 Place	of Death	1 Yes :	2X2 No	1 🗆 Yes	2 No
<u>=</u>	Attending Physician: r death. sctor: Atter this certific by the funeral director.	ToB	examiner? 1 ☐ Yes 2 🕱 No	Hospital:	ent 2 ER/Out	patient 3 1	DOA Othe			5 Reside		Other (Specif	v)
0	ng Ph ter th		27. Manner of Death 1 Matural 5 □ Pending	28a. Date of Inju (Month, Day			28c. Injury Work	at		d. Describe ho			,,
<u>0</u>	endir aath. or: At	atic	2 Accident investigati	ion	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	M		Yes 2□N	lo				
ž	l or Att efter de Direct	Certification:	3 Suicide 6 Could not determine		ury - At home, far c. (Specify)	m, street, fact	ory, office		28	f. Location (St City or Town	reet and No. State)	umber or Rura	l Route Number,
Ω	ospital of hours of unerel D												
	Mospita 24 hours Funerel etely filled	edical	29a. Certifier (Check only one)  2 Medical Exponent	Physician: To the best of aminor: On the basis of and manner sta	f examination and	, death occurre vor investigation	ed at the time on, in my of	ie, date and pinion, deati	i place, an n occurred	d due to the ca at the time, d	ause(s) and ate and pla	f manner as s ce, and due to	ated. the cause(s)
	To the Hospital or Attending Physician: within 24 hours eller death. To the Funerel Director: After this certific completely filled in by the funeral director.	Me	29b. Signature and title of certifier	and mainer ste	1.00.		9c. License	number		2	9d. Date si	gned (Month,	Day, Year)
	P > P 0		DL.	2001	A A D			1370				24/0	**
1			30. Name and address of person with	o completed cause of d	eath (Item 23a)	Type, Print)	270	010			, ,	5110	
	5+1		Peter L. Wisn				ter B	Blvd.	Dunki	irk, MD	207	54	1
	Sta		31. Date filed (Month, Day, Year)	32. Registra	s Signature					•	-		
	Registr	ar	OCT	2 6 2006	Victory o	15. An	SALL						

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Registrar

			1 - For State Registrar	Sta	te of N	Marylar				lealth a Death	and Me	ental Hygi	ene g. No. (	2006	35	625
			Decedent's Name (First, Middle	Last)				· tirroa		304.77	1	2. Date of Death		_000	3. Time of	Death .
	Physici	an		,	olf							Month	Day	Year		
E	/Medio		Marie E.  4a. Facility Name (If not institution,			201		4b Cib	Tours or	Location o		October		county of Deatl	12:22	Р
Ž.	Examir	er					206						40.0			
			15115 Interla							er Spr		0.00-11-1014		Montg		
	Funeral		,	6. Sex 1 ☐ M 2l			last birthday) Yrs.	Months		Hours	Min.	<ol><li>Date of Birth (Month, Day,</li></ol>		Co	nplace (State o untry)	r Foreign
	Director		711-12-1747 Usual Residence of Decedent			86	) ''3'				M	larch 3,	192	0 Vi	rginia	
	and **		10a. State 10b. County			10c. Ci	ty, Town or Lo	ocation							10d. Inside Ci	tv Limits
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	d within 72 hours after death with the Maryland Jene. Than "natural", or Itema 23e or 28e-f show It a Medical Examinat must be notified at				_			101. 21	p Code		_	10	g. Citize	on of What Co	untry?	
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36	or l	by F	1 Never Married 2 Marri	If Y	]Yes 2 <b>1</b> es, Give			1 🗆 Yes	21 No	Specify:			s	Specify: Whi	te	
21215-0036	ural'		3 Widowed 4 Divorced		ar or Date	S:					-					
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	filed within Hygiene. other than				2		Gli	t Sh	op Ov			.=.		etail		
2	tal H	Be	17. Father's Name (First, Middle, L									(First, Middle, M		umame)		
$\frac{8}{8}$		은	Frank R. Monro									outenbu:			0.0	000
Maryland	2 sho	11	19a. Informant's Name/Relationsh Janellen Wolf			n 7 ar	1	-				Route Number,			ip C008)	906
	s 1 and 2 should f Health and Mer flem 27 is marke other traumatic			/ baugii	cer-1	-				chen		e, Apt.				.ng, r
altimore,	of H of H of He f Ite		20a. Method of Disposition  X□ Burial 2 □ Cremation	3 Demovs	I from Sta		Place of Dispo cemetery, crea	osition (Na matory or	me of other plac	θ) N	Da [ovem]	ber 4,	0c. Loca	ation - City or	Town, State	
Ĕ	permit. Pages Department of I Important: If Its any Injury or o once.		4 □Donation 5 □ Other (Sp		ii ii Oiii Sta	"Gat	e of Hea	even C	emeter	У	200		ilve	r Spri	ng, Mar	yland
a	partr portr y Inji		21. Signature of Funeral Service L	icensee	-0-11	the.	F2	alleria	gd Addres	~6719119	ns F	uneral 1	Home	Inc.		
m	89558		1 Agrees =	s Oc	B							W, Sil			, MD 20	901
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications	that caus	ed the dea	th. Do not en	ter the mo	de of dyin	g, such as	cardiac or	respiratory arre	st,		Approximate	9
	Physician		Immediate Cause (Final				_1, _ 2,		D. 2						Onset and D	Death
À	/Medical		disease or condition resulting in death)	d		as a consec	zheime	rs	Disea	ise					3 Year	'S
	Examiner					20 2 001100	4401100 01).									
ц		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	ue to (or i	as a concec	quante of):									
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8760	cate be executed physicien and the burial-transit	ie														
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×	eath certific ettending p for use as	/We	IF FEMALE:	23c. If v	es. outcon	ne of pregn	ancv							d Data of data		
Rox	eath etter for u	cian/M	23b. Was decedent pregnant in the past 12 months?	1	Live birth	2 Feta	aldeath 3[	Ectopic p					23	<li>d. Date of deli- Month</li>		/ear
o.	the d	ysic	1 ∐ Yes 2 🙀 No 9 □ Unknown		Unknown		36au 36	_ Other (s	Decity)							
7	law requires that the death certifi es been signed by the ettending i 2 should be detached for use as	Physi	Part II. Other significant condition	ns contributir	or to death	hut not res	sulting in the u	inderlying i	Palleo Alve	an in Part I		23e Did tob	acco use	contribute to	the cause of d	eath?
Records,	signe signe	by	Chronic Obstruc						outoo give			1 🗆 Yes			bably 4 🗆	
5	neen een	Completed										1 10:	- 20	NO 3   FIC	Joaciy 4 🗆 C	TIKTIOWIT
ပ္	law es b	ple										24a. Was an autopsy		24b. Were aut	topsy findings a ompletion of ca	available
Y	The law sete hes page 2 t	Ю										perform	ed?	death?	2□ No	
Vital	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical							26. Place	of Death	Check only one				
	G in	To	examiner? 1 ☐ Yes 2 ☐XNo	Hospital	l: 1 🗌 Inpa	itient 2	ER/Outpatier	nt 3 D	OA Othe			e 51 Resider		Other (Spec	afv)	
	ding Phy I. After the funeral		27. Manner of Death		Date of It	jury Day Year)	28b. Time o	f	28c. Injury Work	at		8d. Describe hov			**	
ਠੁ	Attending in death.  •ctor: After by the funer	atio	1X Natural 5 ☐ Pending 2 ☐ Accident investig		(NOTION), L	Jay (Gai)	піцагу	м		Yes 2□N	No					
Division	Atte	Ę	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		Place of	Injury - At h	ome, farm, str	reet, factor	y, office		28	Bf. Location (Stre	et and	Number or Ru	ral Route Numi	ber,
בֿ	spital or ours efte seral Dir filled in	Certification:	4   Hollicide		building,	etc. (Speci	ry)					City or Town,	State)			
	pspit hours inera y fille		29a. Certifier 1 XCertifying	Physician:	To the be	st of my line	owledge, dest	fi uccurred	at the tim	ie, date and	J place, a	id due to the car	rea(e) a	nd manner as	statad.	
	P Fu	edicai	(Check only 2 Medical E	Examiner: Or	n the basis d manner	of examina	ation and/or in	vestigation	n, in my op	oinion, deat	h occurred	d at the time, da	e and p	lace, and due	to the cause(s)	)
	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the to	Me	29b. Signature and title of certifier					29	c. License	number		29	d. Date :	signed (Month	. Day, Year)	
	10		Dame of	un	44	0			D 24	1543			0c	tober :	23, 200	6
	f.,		30. Name an address of person v				n 23a) (Tyne	Print)								
			James A. Rossi						or1d	Blvd,	Sil	ver Spr:	ing.	MD 20	906	3
	Sta	te	31. Date filed (Month, Day, Year)			strar's Sign		100				-1	- , ,			
Á	Registr		OCT 2 4	2006	Rana.	1	y. God	MEL								

		For State Registrar	State of Marylar			f Health ar	nd Mental	Hygien	/1116	35626
Physi /Med Exam	lical	Decedent's Name (First, Middle, Last     A	LEWIS	0.1	l	U. Son	) Octo	of Death th D	ay Year 23, 2006	3. Time of Death 2:28 4 <sup>M</sup>
Funera Directo		5. Social Security Number 5.79-42-9714 Usual Residence of Decedent	TM XTE	last birthday) 74 Yrs.	If Under 1 Ye Months Da		Min. (Mon	of Birth th, Day, Year 31, 19	9. Birth Cour 132 Penns	place (State or Foreign ntry) sylvania
th the Maryland or 28e-1 ehow	Director	10a. State 10b. County  Maryland Carroll  10e. Street and Number		ty, Town or Loc chester		ie		10g. C	itizen of What Cou	10d. Inside City Limits 1 Yes 2 No
Baltimore, Maryland 21215-0036 permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Ptyglene. Important: If Hem 27 is marked other then "natural", or items 23s or 28s-1 show eny Injury or other treumatic event, the Medical Examiner must be notified at	by Funeral	3241 Lineboro Road  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Force s? 1 ☐ Yes ※☐ No If Yes, Give Year or Dates:		21102 Vas Decedent of Yes, specify C	of Hispanic Origin Cuban, Mexican, F No Specify:	n? (Sp <i>eci</i> fy Yes Puerto Rican, et	USA or No- c.)	14. Race - Americ Black, White, Specify: Whi	etc.
id 21215-0036 flied within 72 hours af Hygiene other then "naturel", or ent, the Madical Exprin	e Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)		(Give k	O NOT use re	ne during most o tired)	of working  s Name (First, N	Own	Kind of Business/In  Home  n Surname)	dustry
Maryland nd 2 should be file lith and Mental Hy 27 le marked oth	To Be	William Henry Lewi 19a. Informant's Name/Relationship (7)		19b. Mailing	Address (Stre		Georgi		gle or Town, State, Zip	Code)
Baltimore, Ma Demit. Pages 1 end 2 Department of Heelth a mportant: If Nem 27 le		James Burton Helfr  20a. Method of Disposition  1 Burial 2 Acremation 3 F  4 Donation 5 Other (Specify)	Removal from State	Place of Dispos cemetery, crem	atory or other		Date	20c. L	ocation - City or To	
Baltir permit. F Departme Importer eny Injur		21. Signature of Funeral Service Licens	La Me MOI	22. Go 251 Be	Name and Ad ing Hor verly	L. Heckr	tion Se	rvice	tsville, P.O. Box arksville	x 784 e, MD 21029
Physician /Medica Examine		23a. Part1. Enter the disease, or complished, or complished, or complished the cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a. RESPIRATION  Due to (or as a consect  Due t	Y FAI Vence of):	ilurz	CRHAGE		ory arrest,		Approximate Interval Between Onset and Death  Aug.  Anouth
8760, cate be executed physicien and	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	Anky	yın				1	month
of Vital Records, P.O. Box 61 Physician: The law requires that the death certific this certificate has been signed by the attending p rail director, page 2 should be detached for use as	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 The 9 Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3⊟8	Ectopic pregna Other (specify)				23d. Date of delive Month	ery Day Year
0 8 6 B	þ	Part II. Other significant conditions con	ntributing to death but not res	ulting in the und	derlying cause	given in Part I.	23e.	Did tobacco	use contribute to the	
tal Reconn: The law rificete has be or, page 2 sh	e Completed	25. Was case referred to medical					101	Was an autopsy performed?	death?	psy findings available inpletion of cause of
ding After	ertification; To B	examiner?	fospital: 1 Inpatient 2  28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. In	Other: 4 🗆 Nursii	28d. Desc		6 □Other (Specify	()
Division To the Hospitel or Attention 24 hours after deal To the Funeral Director:	O	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	v) 			City	or Town, State		
To the Hospitel or within 24 hours after To the Funeral Dir	Medical	one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	windga death tion and/or inve	estigation, in m	y opinion, death o	place, and due to occurred at the t	ime, date an	d place, and due to	the cause(s)
of play	-	29b. Signature and title of certifier				-00			te signed (Month, 1 1) bel 23	
) BS		30. Name and address of person who co	600 N.W.	DIFE S.	t. BAI	timbe E	, MARU	land	21287	>
S Regis	tate trar	31. Date filed (Month, Day, Year) 007 2 5 20	32. Registrar's Signa	ture	Bet.		/			

		For State Registrar	State of Maryla	and / Dep	artme	nt of H		-			356
Physicia /Medica Examine	al	4a. Facility Name (If not institution, give	HOMAS WHI	TE			Location of Dea	2. Date of De Month October	22 22	County of Dea	
Funeral Director		5601 RIDGE ROAD  5. Social Security Number 213-38-1195  Usual Residence of Decedent	7. Age (In y	rs. last birthday, 2 Yrs.		OUNT er 1 Year Days	If Under 24 Hrs Hours Min				thplace (State or For ountry) Maryland
h the Maryland r 28a-f show	irector	Md. Carro.  10b. County Carro.  10e. Street and Number		City, Town or Li Mount	Airy	ip Code			10g. Citiz	en of What Co	10d. Inside City Lin 1 Tyes 2
ING 21215-0036 be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23a or 28a-f show event, it a Medical Examinar must be notified at	by Funeral Director	5601 Ridge Road  11. Marital Status  1□ Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 ∐ Yes 2. ☑ No If Yes, Give		Was Dec If Yes, sp	/	21771 ispanic Origin? (Specify:	Specify Yes or No to Rican, etc.)	)- 1	United  4. Race - Ame Black, White  Specify:	
Maryland 21215-0036 d 2 should be filed within 72 hours at th and Mental Hygiene. 7 is marked other than "natural, or traumatic event, it a Mudical Exam	Completed b	3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grad  Elementary/Secondary (0-12)  1.2	Year or Dates:	16a. Dece (Give life.	kind of w DO NOT	ual Occupa rork done d use retired	ation during most of wo	orking	16b. Kin	d of Business	/Industry
Maryland 2 2 should be filed i and Mental Hygic Is marked other reumatic event, II	To Be C	17. Father's Name (First, Middle, Last) Harry Griffith  19a. Informant's Name/Relationship (Ty	White	19h Maili			Margar	me (First, Middle et How	Maiden S ard	Sumame) Riggs	6
Heat and the series of the ser		Diane Hinkle / D  20a. Method of Disposition  1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)	aughter 20t	P. Co. Place of Dispo	osition (Namatory or	x 444 ame of other plac	, Davis	Date	Virgi 20c. Loc	nia 2	6260
Definition permit. Pages Department of I Important: If Its any reluty or of		21. Signature of Funeral Service Licens  Murul #	Barke	25	Name a Mur P.	and Addres	s of Facility Barber ox 5038	r Funera , Layton	l Hom svill	ne	20882
ysicie	dicai Examiner	23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons  Due to (or as a cons  Due to (or as a cons	equence of):  equence of):  equence of):	ecrt rter nelli	four y d hs	lure lisease				Approximate Interval Between Onsey and Death III III III III III III III III III I
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w requires that been signed be should be deta	ا ۾	Part II. Other significant conditions cor	tributing to death but not r	esulting in the u	nderlying	cause give	en in Part I.		obacco uso res 2 🗖		the cause of death?
ding Physician: The law requires the ham to the second the second through the second through the second through the second director, page 2 should be continued to the second through th	e Completed	25. Was case referred to medical					Of Pinns of Da	24a. Was autor perfo 1 Yes	med 2 No	prior to death?	itopsy findings availa completion of cause 2 No
ysicl. is cer direc	0	examiner?	ospital: 1   Inpatient 2	☐ ER/Outpatier	nt 3 D	OA Othe		tome 5 Resid		Other (Spec	cufu)
or Attending Physeler death.  Director: After this I in by the funeral di		27. Manner of Death  1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f M	28c. Injury Work 1 🔲 1		28d. Describe			//
Ital or rrs efte ral Dire		4 Homicide determined  29a. Certifier 1 Certifying Phys	28e. Place of Injury - At building, etc. (Spe sician: To the best of my k	nowledge deat	OCCUPIED	l at the tim	a date and place	City or Tov	vn, State)	nd manner as	ural Route Number,
To the Hos within 24 h To the Fur	Medical	(Check only 2 Medical Examinations)  29b. Signature and title of certifier	Penjan	nation and/or in	vestigation 29	in my op	number	urred at the time,	date and p	signed (Mont)	to the cause(s)
State		30. Name and address of person who consumer of the second	mpleted cause of death (III  Paper, I  32. Registrar's Sig	981 <sup>c</sup>	Print)	Stree		us, MD 20	872	10	7 - 70

DHMH 17 Rev 1/2001

amend 23a per Dr. e863 1/18/07 KBH lease Type of Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** OCT 2006 TILIER DEAVON WOODS-COLE 14 8:03 A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY NATIONAL NAVAL MEDICAL CENTER BETHESDA If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 40 October 14, 1 💢 M 2 🗆 F 2006 Maryland None Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 27 is marked other than "naturel", or iteme 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 Yes X No Directo Waldorf Maryland | Charles 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20602 US 2230 Harford Court by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours affer of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel; or item only injury or other traumatic event, the Mudical Exemperators. Black, White, etc. 1 ☐ Yes 2 X No 1 X Never Married 2 ☐ Married Black 1 Yes 2 X No Specify: Specify If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Infant 0 None 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Tiffani L. Woods Henry William Cole, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2230 Harford Ct., Waldorf, MD 20602 Tiffani L. Woods - Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Waldorf, Maryland 10-18-06 Huntt Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M01391 3035 Old Washington Rd. Huntt Funeral Home POB 156, Waldorf, MD 20604 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** LIMB-BODY WALL COMPLEX Lethal Congenital Anamally disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Squentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine aftending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ pege 2 should be 24 No 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy lindings available prior to completion of cause of death? 24a Was an has autopsy performed? (es 2 \textbf{\textit{A}}\text{No certificafe 1 Yes 1 Yes After this certification funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 X Inpatient Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 XNatural 5 Pending death. investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be delemined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician:

the Maryland

Baltimore, Maryland 21215-0036

State Registrar

LT MC WESLEY R. HODGSON 31. Date filed (Month, Day, Year) strar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) USN

D-0061988

29c. License number

29d. Date signed (Month, Day, Year) ctober 19,2006

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

OCT 2 4 2006

29b. Signature and title of ceptifie

**ORIGINAL** 

			For State	State of Marylan		nent of Health and cate of Death		/11116	35629
			Registrar  1. Decedent's Name (First, Middle, Last)		Ochanc	Date of Beatiff	2. Date of Death	J. No. 12 0 0 0	3. Time of Death
	Physici /Medic		Alice R Wi	ckes			October	22 2006	7:30 PM
	Examin	er	4a. Facility Name (If not institution, give s University of Mary &		inter 146.	City, Town, or Location of Dea Baltimore	th	4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 220 - 32 - 7853 1□	M 20 F 7. Age (In yrs.		Inder 1 Year II Under 24 Hrs hths Days Hours Min		9. Birth	place (State or Foreign
	aryland •how	)r	Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Location	24/			10d. Inside City Limits 1 X Yes 2 □ No
	or 28a-1	Director	10e. Street and Number	a U	LSTEKT)	f. Zip Code	10g	g. Citizen ol What Cou	
	Jeath w	Funeral [	120 PROSPECT	2. Was Decedent Ever in U.	S.   13. Was E	Decedent of Hispanic Origin? (	Specify Yes or No-	14. Race - Ameri	can Indian,
920	be filed within 72 hours after death with the Maryland stal Hygiene. ad other than "natural", or Iteme 23s or 28s-f ehow event, Ite Medical Exartinal matter codified at	þ	1 Never Married 2 Marned 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	If Yes,		to Rican, etc.)	Black, White,	etc.
21215-0036	n 72 ho "natur e alcei	Completed	15. Decedent's Educ (Specify only highest grade		(Give kind o	Usual Occupation of work done during most of wo QT use retired)	orking 16	Sb. Kind of Business/Ir	ndustry
	filed withi Hygiene. Ither ther		Elementary/Secondary (0-12)	College (1-4or 5+)	Donus	he/Maid	L	Vashingte	N College
Maryland	e d a b	To Be	17. Father's Name (First, Middle, Last) (MARUS E. L	vicks		Mai	me (First, Middle, Ma	NOON	
	ith ar th ar 27 is r trau	-	19a. Informant's Name/Relationship (Type Juck 4) Strika	re. Print)	19b. Mailing Add	dress Street and Number or R	VZ Tamper, C	City or Town, State, Zi	MD 20148
Baltimore,	Pages 1 ar nent of Hea int: If Item ; iry or other		20a. Method of Disposition  1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State	lace of Disposition emetery, crematory	(Name of or other place)	28/2006 E	C. Location - City or To	own, State
Balti	permit. Pages Department of Important: If I any njury or once.		21. Signalury of yun ral Salvice License	Rolling		ne and Address of acility	-11 hit	i MK	-1 1145
			23a. Part 1. Priter the disease, or complice shoek, or heart failure. List only on	ations that caused the death	n. Do not enter the	mode of dying, such as cardia	c or respiratory arres	1. / 11 🔼	Approximate Interval Between
}	Physician /Medical		Immediate Cause (Final disease or condition resulling in death)	Pulmon	ary En	nbolus			Onset and Death
ŀ	Examiner		Sequentially list conditions, b.		ovascul	ar Accid	lent	1	4 days
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	uence of):				ı
8760,	te be executed ysicien and e burial-transit	dicai Ex	resulting in death) Last	Due to (or as a consequ	uence of):				
9	ertificete ling physi e as the l	Medi	IF FEMALE:		VIII.				
O. Box	The law requires that the death certificate be executed that been signed by the attending physicien and bage 2 should be detached for use as the burial-transi	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 No 9 □ Unknown	ic. If yes, ouIcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 Ector	pic pregnancy or (specify)		23d. Date of deliver Month	ery Day Year
٦.	es that the gned by be detact	by Ph	Part II. Other significant conditions conf	ributing to death but not resu	ulling in the underly	ing cause given in Part I.	23e. Did toba	cco use contribute to t	
Records,	w requires that been signed b should be deta	eted	Hypertension				1 ☐ Yes 24a. Was an	2 No 3 Prot	
		Completed					autopsy performe	prior to co death? 1 Yes	opsy findings available impletion of cause of
Vital	ysician: iis certifica director, i	o Be	25. Was case referred to medical examiner?	ospital:	ER/Outpatient 3	Othor	ath Check only one)	ce 6 Other (Specif	4.1
Division of	\$ 5 m	- 1	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury al Work?	28d. Describe how		<i>y)</i>
SINIS	or Atten efter dea Director in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, larm, street, fa		281. Location (Stree City or Town,	et and Number or Rura State)	al Route Number,
	To the Hospital or Attending Physician: within 24 hours lette deals to the Funeral Director. After this certific completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one) 1 V Certifying Physical Examination (Check only one)	cian: To the best of my known of the basis of examinat and manner stated.	wadya Jeath centi tion and/or investiga	irred at the time, date and place ation, in my opinion, death occi	and due to the eaut urred at the time, date	se(s) and manner as a and place, and due t	lated. o the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	11		29c. License number	29d	. Date signed (Month,	Day, Year)
}	3		1 Jeans	Seller	M.D.	17466	de	tober 22	,2006
-			30. Name and address of person who cor	ned cause of death (Item 22 Sout	23a) (Type, Print)	17466 ne Street B	olk	MD 212.	2.0
	1 m Sta	te	31. Date liled (Month, Day, Year)	32. Regitrar's Signa	ture	IE SWEET 17	ultimore,	MU LIL	20
	Registr	ar	OCT 2 6 2	UU6 Magas	1. Mar	rette 1			

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Dorothy Wheeler Oct. 1324 M 25 2006 4c. County of Death Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Regional Medicas Center alisbury Wicomica Peninsula If Under 1 Year | If Under 24 Hrs Social Security Number 9. Birthplace (State or Foreign Months Days 11/20/1941 Hours New York 64 263-60-8628 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 T¥es 2 □ No Wicomico Salisbury Maryland 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 504 Truitt St. 21801 USA 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: white 3 ☐ Widowed 4 K Divorced

16a. Decedent's Usual Occupation

Homemaker

20b. Place of Disposition (Name of cemetery, crematory or other place)

Salisbury Crematory

(Give kind of work done during most of working life. DO NOT use retired)

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

10a. State

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

Charles A. Travis

4 ☐ Donation 5 ☐ Other (Specify)

19a. Informant's Name/Relationship (Type. Print)

Dorothy Cartwright/daughter

1 ☐ Burial 2 X Cremation 3 ☐ Removal from State

12

College (1-4or 5+)

**Funeral** 

Director

28a-f show

Director

Funeral

þ

Completed

Be

and 2 should be filed within 72 hours after death with the Maryland eaith and Mental Hygiene.

3altimore, Maryland 21215-0036

Box 68760.

P.O. |

Division or Vital Records.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified it

attending physician the !

Immediate Cause (Final disease or condition resulting in death) ACU TE MYOCARDIAL INFARCTION Due to (or as a consequence of): PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner EMPHYLEMA PULMONARY Due to (or as a consequence of): NICOTINE ADDICTION Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 OSTEUPOROSIS Completed ARTHRITIS RHFUMATOID To the Hospital or Attending Physician: within 24 hours after déath.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 1 Yes 2 No Other: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. SHIRAZI, M.D. PENINSULA REGIONAL MEDICINE. MD 21801. 31. Date filed (Month, Day, Year)

21. Signature of Funeral Service Ligenses AdTroway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Hours 2 DAYS 10 YEARS SO YEARS 23d. Date of delivery Month

> 23e. Did tobacco use contribute to the cause of death? 1 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 2□ No 26. Place of Death (Check only one) 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

16b. Kind of Business/Industry

20c. Location - City or Town, State

Salisbury, MD

Domestic

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Elizabeth

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

10/30/06

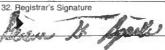
504 Truitt St., Salisbury, MD 21801

29d. Date signed (Month, Day, Year)

OCTOBER 26, 2006

State Registrar

NOV 0 9 2006



Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

AMEND 111-M/15-16b, periff, 6861, 11/6/06, ws

State of Maryland / Department of Health and Mental Hygiene 2006 For State Registrar Certificate of Death Rag. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 21, Maryann (NMN) Whetzel 2006 19:00 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Harford Bel Air 1328 Banyon Circle If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) If Under 1 Year Months Days Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 1 □ M 25 F May 24, 212-70-5130 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10b. County 1 TYAS 2 NO Maryland | Harford Forest Hill 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21050 1624 Michelle Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Marned 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+)

2 years Elementary/Secondary (0-12) None None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Katherine L. Starner Robert W. Whetzel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 302 Princeton Lane, Bel Air, Maryland 21014 Brian Berry / Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 10-25-06 Olivet Cemetery 21. Signature of Fun and Julyio Robert E. Dailey & Son Funeral Homes, P.A. 1201 N. Market Street, Frederick, MD 21014 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that earlied the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Immediate Cause (Final disease or condition resulting in death) Hear anotic Due to (dr)as a consequence of): Due to (or as a consequence of): U Sh Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2XNo 3 Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed? 1 ☐ Yes 22 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Aunt's Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖾 No Residenc 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Natura 5 Pending

/Medical Examiner Examine nding physician and ise as the burial-transit Ta Box 68760, Physician/Medical detached for Division of Vital Records, P.O. been sig

s after dec. filled in by

Ď

Completed

Be

Certification:

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

rthen "natural", or Iteme 23a or 28a-f ehow Ite Medical Examinar must be notified at

death

filed within 72 hours after

If Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 le marked oth any njury or other treumatic event ence.

Physician

Baltimore, Maryland 21215-0036

**Funeral Director** 

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Completed

Be

To the Hospital o within 24 hours aff To the Funerel Di completely filled in

ō

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHIPI KHOSGA 206 HAYS ST #102, BEL AIR, MD 21014 31. Date filed (Month, Day, Year)

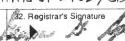
NOV 0 6 2006

29b. Signature and title of certifier

20 haile

investigation

6 Could not be determined



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D56545

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rura! Route Number, City or Town, State)

10/23

29d. Date signed (Month, Day, Year)

06

#### 06-07605 Zhen Qiang Zhang

Please Type or Print in Black Indelible Ink

en Qiang Zha	_	1- For State	State	of Maryla	•	irtment of	Health and	d Menta	ıl Hyg		0.0	00/	
Physici		Registrar  1. Decedent's Name (First,	Middle,La:	st)					2	Date of Deat		LŲ;	3. Time of Death
dical Exam		ZHEN	QIA		IANG					Month October 8			2130 hrs
		4a. Facility Name (if not ins Suburban Hospita		ve street and nu	mber)	4	b. City, Town, or I Bethesda	Location of E	Death		4c. County of Montgom		
Funeral		5. Social Security Number	6. S	Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 2	24Hrs.	8. Date of 8in	th(MM/DD/YYYY)	-	nplace (State or
Director		216-65-219	13 12	<b>∑</b> M 2□F	46	Yrs.	Months Days	Hours	Min.			Foreign	
Α.		Usual Residence of Deced	ent		1								
ow an		10a. State 10b. Co		omery	10c. City,	Town or Location	ckville						10d Inside City Limits 1 X Yes 2 No
ıryland ta-f sh	ctor	10e. Street and Number					10f. Zip Code			11	0g. Citizen of Wha	at Count	
5-0036  Index within 72 hours after death with the Maryland Hygiene.  other than "natural", or items 23a or 28a-f show any the Medical Examiner must be notified at once.	Director	109 North	Str	ceet			208	50			China		,
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urs afte tura!" amine	d by	15. Decedent's Education		or Dates:			Yes 2 X No		id of wor	k done	Specify: 16b. Kind of Bus		nese
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15-0 filed al Hyg ed oth t, the	Be Co	17. Father's Name (First, M Guo Cha		•			1			irst, Middle, M ng Ya:	Maiden Surname) n Ci		
212 ould be Ments mark ic even	To B	19a. Informant's Name/Rel	-	_		19b. Mailing	Address (Street			_	nber, City or Town	, State,	Zip Code)
imore, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene arts: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	Ι.	Chei Hua		g (Wife							ille, M		
or Heal		20a. Method of Disposition  1 Burial 2 X Crei		Removal fr		Place of Disposi crematory or oth	tion (Name of cen er place)	- 1		Date	20c. Location -		
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Baltimore, permit. Pages I and Department of Heal Important: If item injury or other tra		21. Signature of Funeral S	acar Lige	An Mi	Non.	/							MD 20850
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	ner	Sequentially list conditions if any, leading to immediat	e	Due to (or as a	consequence o	f);					<u> </u>		
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O,  be executed sician and ourial - transi	edical	UNPENDED		AMENDED									
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Box 6876  e death certificate the attending phy ed for use as the k	sician/M	past 12 months?	Unknow	4 Pregr	nant at time of de	ath	ner (Specify)		-9	,			
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Divis spital or A hours after meral Dire	erti	3 Suicide 6 4 Homicide	Could no determin		Major Roa	d / Highway				or Town, S	State)		Avenue, Rockville
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2	2	Signature and title of	//	. /			O.C.N				29d. Date signe October 10.		
		30. Name and address of	TACLES person who	completed car	se of death (Item	1 23a)	0.0.1				J Colober 10,		
		Pamela E. South	all, MD		Medical Exa	,	1 Penn Street	t, Baltimo	re, MI	21201			
Pari	State	31. Date filed (Month, Day	2 <sup>ar)</sup> 6	2006 32.	egistrar's Signat	M. Ana	de						

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State of Maryland / Department of Health and Mental Hygiene

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ledical Exami	ner	John Allen	Zsidis	sin					Month Octobe	r 16, 2006	Year	1515 hrs
		4a. Facility Name (if no	t institution, gi	ve street and number)		4	b. City, Town, o	or Location of D	Death	4c. (	County of Death	1
		3709 Portal Av	enue				Temple Hi	lls		Pri	ince George	e's
Funeral		5. Social Security Numb	ber 6. S	ex 7. Age	(In yrs. las	t birthday)	If Under 1 Ye			Birth(MM/D		thplace (State or
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21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	To B	19a. Informant's Name/				10h Mailing	Address (Stre		er or Rural Route I		or Town State	Zin Codo\
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and 2 ealth em 2		20a. Method of Disposi		2011	20b. Pla		ion (Name of c		t Way S		cation - City or	
ore of H				Removal from Sta	te cre	ematory or oth	er place)					
Pag ment ment		4 Donation 5			Che	sapeak	e Crema	tory	10/24/06	Be1	tsville	e, MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Shi I	21. Signature of Funera	al Service Lice	nsee		2. Na O 1	me and Addre	ss of Facility Cremat	tion Ser	vice	P.O. Bo	ox 784 Le, MD 21029
		Bever 1	h He	ability-								
Physician		23a. Part I. Enter the di failure. List only o			the death. D	Do not enter th	e mode of dying	g, such as card	diac or respiratory	arrest, shoc	k, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Fina		Atherosclerotic	Cardiova	scular Dise	asse					Death
)		or condition resulting in	n death)	Due to (or as a conse	equence of):							
	<u>.</u>	Sequentially list conditi	ions,									
	miner	if any, leading to immed cause. Enter Underlying	ng Cause	Due to (or as a conse	equence or):							
	Exan	(Disease or injury that in events resulting in dear	initiated	Due to (or as a conse	equence of):							
cuted nd transi				l								
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit	Medical	UNPENDED		AMENDED								
'60, ate be	Mec	IF FEMALE:		23c. If yes, outcom	ne of pregna	ancy				23d.	Date of deliver	y
587 artific ling 1	an/	23b. Was decedent prespast 12 months?	gnant in the	1 Live birth		_	al death 3	Ectopic pr	regnancy	N	Month (	Day Year
Box 687 death certificate attending	sician/	1 Yes 2 No 9	Unknow	4 Pregnant at	time of deat	th 5 Oth	er (Specify)					
he de	Phy	VII		9 Unknown		- tr !- tr	deal de second	- In Dead	1 02a D	diahasa		#
, P.O. Bories that the designed by the signed for the s	by	Part II. Other significa	int conditions	contributing to deatr	i but not res	uiting in the ur	idenying cause	given in Part i	,,,,,,,,,		,	the cause of death?
S, F uires n sign Id be				<del></del>					_ )			
Records,  The law require ficate has been sing page 2 should b.	Completed									itopsy		topsy findings available completion of cause of
tal Reco cian: The law certificate has	E								1 ✓ Ye	erformed?	death?	es 2 No
ntifica	ပိ	25. Was case referred	to medical				26.Plac	ce of Death (Ch				
Vital Rec ysician: The his certificate director, page	<u> </u>	examiner?	No	Hospital: 1 Inpatie	nt 2 E	R/Outpatient	3 DOA	Other; N	lursing Home 5	Residen	ce 6 🗸 Other	r: Scene
Division of Vital ist or Attending Physician: is after death.  al Director: After this certiled in by the funeral direction	-: T	27. Manner of Death	INO	28a. Date of Inju	ry 2	28b. Time of In	jury 28c. Inj	ury at Work?	28d. Descri	be how injur		
ion (tending leath.	Certification:	1 V Natural 5	Pending	(Month, Day,Y	ear)		1	Yes 2 No	0			
isic Atte	ica	2 Accident	Investiga	28e Place of In	urv - At hon	ne. farm. stree	t, factory, office	building, etc.	28f. Locatio	n (Street and	d Number or Ru	ıral Route Number, City
Divising pital or At ours after denal Direct filled in by	Ē	3 Suicide 6 4 Homicide	Could no determine	t be	,			0.		n, State)		,
lospi 4 hou uner ty fil		29a. Certifier	rtifuina Physi	cian: To the best of m	, knowlodae	doath accurr	ad at the time	date and place	and due to the c	auco(c) and	manner ee eter	tod
Division  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	lica			er:On the basis of exar								
To To	Medical	29b. Signature and title		and manner stated.				nse number			ate signed (Mo.	
	-	(1/M 1/	20	Il anni	700.	$\wedge$		.M.E.			ber 17, 2006	
		Chris	ere	Tul	ul							-
11/02		30. Name and address		i	•	,	treet, Baltin	nore MD o	1201			
2	9 19	Carol Allan, MI		ant Medical Exan			ueet, Daitin	noie, MD 2	1401			
S <sup>i</sup> Regis	tate trar	31. Date filed (Month C	125	2006 32. Registra	s signature	H Son	all a					
Regis	etell			-46	- A	164000	ANT S					

DHMH 17 Rev 1/2001 OCME 2006

			For State Registrar	State of Maryland		artment rtificate			and Me	ental Hyg	giene	006	3563	34
			Decedent's Name (First, Middle, Last)							2. Date of Dea	ith		3. Time of D	Death
**.	Physici		William Edward	Zachem						Month Octobe	Day 18,	2006	6:00	$A^M$
>	/Medio		4a. Facility Name (If not institution, give stre	eet and number)		4b. City, 7	4b. City, Town, or Location of Death 4c.					unty of Death		
3	45.		Prince George's Hos	pital		Che	ver1	У			Pri	ince Ge	orge's	
o in	Funeral Director		407-14-5943	7. Age (In yrs. It	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours		8. Date of Birtl (Month, Day ) 2 / 23 / 1	918	9. Birthp Coun Kentu	lace (State or try) ICKY	Foreign
	pu *		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation						1	0d. Inside City	Limits
	f eho	ō	Maryland Prince Geo	orges Bow	ri e								1∭Yes 2	2 🗌 No
	28a-	Director	10e. Street and Number	riges bow		10f. Zip	Code				10g. Citizen	of What Cour	itry?	
	3a or	Ö	12211 Maycheck Lane	1		207	715				USA			
	ms 2	Funerai		Was Decedent Ever in U.S	S. 13.			spanic Orig	gin? (Spec	ify Yes or No- lican, etc.)	14.	Race - Americ		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "naturel", or items 23a or 28a-f ehow any njury or other traumatic event, the Madical Examinar mantice motified at ances.	þ	1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Forces?  1 XYes 2 □ No If Yes, Give Year or Dates: 42-		r Yes, spec 1 ☐ Yes 2		Specify:	i, Puerto H	ilcan, etc./		Black, White, ec <i>ify:</i> Whi		
9	72 ho	ted	15. Decedent's Educat (Specify only highest grade of	tion (manufacted)	16a. Dece	dent's Usua kind of wor	l Occupa	tion uring most	of workin	a		of Business/Inc	•	
21	ithin	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT us	e retired)					al Bure	au	
7	ygier ygier tr. th	S		4	Warder	1		10 Matha	ele Alema		Of Pr			
교	be fill d oth	Be	17. Father's Name (First, Middle, Last)							(First, Middle, oot Mon		тате)		
Ĕ	d Mer mark maric	ဥ	Isaac John Zachem  19a Informant's Name/Relationship (Type	Point	19h Mailir	na Address	(Street a					own, State, Zip	Code)	
Ma	id 2 si Ith an 27 Is r traur		Mary Susan Zachem/									ton, DO		
ē,	Heal tem		20a. Method of Disposition	20b. P	lace of Dispo emetery, crei	sition (Nam	e of			ate		tion - City or To		
JO T	Pages ent of tr: If i		1 A Burial 2 ☐ Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	,			- 1	10/24	/2006	Ashla:	nd, KY		
Baltimore,	nait. I		21. Signature of Funeral Servica Licensee									Funera	1 Home	
ä	20 E 2 9		John Husty			16000	Anna	apoli	s Roa	ad Bowi	e, MD	20715		
,	Physician		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	tions that caused the death cause on each line.  Caydb  Due to (or as a consequence)		_				4			Approximate Interval Betw Onset and Do	reen
100	/Medical Examiner			Due to (or as a consequ	uence of):	C Cont o	-Siz	1/5	In fo	wild;	CM		We	ek.
	pe tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):			•						
ó	ate be executed nysicien and he burial-transit	Examiner	Cause (Disease or injury that initiated events c resulting in death) Last	Due to (or as a consequ	uence of):									
3760,	ate be nysicie he bu	Icai	<b>d</b>											
<b>68</b>	ertifica ing ph e as t	Med	IF FEMALE:											
.О. Вох	The law requires that the death certifica ite has been signed by the attending ph page 2 should be detached for use as in	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3	⊒Ectopic pro ⊒ Other (spe					230	I. Date of delive Month	-	ear
Ω.	quires that n signed b ald be deta	þ	Part II. Other significant conditions control	buting to death but not rest	ulting in the u	inderlying ca	ause give	on in Part I.			obacco use res 2 🖼	contribute to the	ne cause of de eably 4 ∐Ui	
Division of Vital Records,	The law requires ate has been sipage 2 should I	Completed										death?	psy findings a mpletion of ca	vailable use of
ta	ticien: T certificat rector, pa	BeC	25. Was case referred to medical examiner?						of Death	(Check only o	ne)			
<u>&gt;</u>	d is	2	1 ☐ Yes 2 ☑ No	spital: 1 Inpatient 2 🗆	ER/Outpatie			4 🗆 190				Other (Specif	y)	
D C		on:	27. Manual of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		8c. Injury Work			8d. Describe h	now injury o	ccurred		
isio	Attending it death. ector: Afte by the fune	licati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At ho	ome, farm, st	M reet factory		res 2 □ i		8f. Location (5	Street and N	lumber or Rura	ul Route Numb	ρθ <i>Γ</i> ,
Ο̈́	itel or A	Certification:	4 Homicide determined	building, etc. (Specify	v) 				and the state of	City or Tov				
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edicai		cian: To the best of my kno r: On the basis of examina and manner stated.										
	To the within 2 To the comple	×	29b. Signature and title of outlifier	west	M	290	License		3/	6	29d. Date s	igned (Month,	Day, Year)	
	1541		30. Name and address of person who com	pleted cause of death (Item	23a) (Type,	Print)	591	Line	N.	Are	colle	25e	2001	(A)
	St Regist	ate rar	31. Date filed (Month, Day, Year)  OCT 2 3 200	32. Segistrar's Signa	ture	book	,							

/Medi	ian	1. Decedent's Name (First, Middle, Last) Estelle Allen				2. Date of Dea Month		3. Time of Dea 4:00p	
Examir		4a. Facility Name (If not institution, give street and nur	m <i>ber</i> )	4b. City, Town, o	r Location of Dea		4c. County of D	L	
LAGIIII		Sinai Hospital			imore		n/a		
Funeral Director		5. Social Security Number 212-40-041 5 1 M 2 K	7. Age (In yrs. last birthday) 66 Yrs.	Months Days	If Under 24 Hr Hours Mir		y. Year) 2-1940	Birthplace (State or For Country)	
MON W		10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Lir	
a-f ah Illiad	ctor	MD n/a	Baltim	ore				1√∑Yes 2 □	
or 28	Dire	10e. Street and Number		10f. Zip Code			10g. Citizen of What	Country?	
ilone. rthan "natural", or Itams 23e or 28e-f ahow the Medical Examinations De notified at	by Funeral Director	5227 Cuthbert Avenue  11. Marital Status  1 Never Married 2 Married  3 Wildowed 4 Divorced  12. Was Dec. Armed Fc 1 Yes, Gir	21⁄⊆1No ve	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	1215 lispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	Specify f r	merican Indian, Inite, etc. 'ican- erican	
ne. han "natu e Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (	(Give	dent's Usual Occup bekind of work done DO NOT use retired IEStiC	ation during most of wi d)	orking	self-Em	ess/Industry	
od othe	To Be Co	6th 17. Father's Name (First, Middle, Last) John Jackson	Dom	lestic		ame (First, Middle, ce M. Ja			
th and Mer 7 is marke traumatic	1	19a. Informant's Name/Relationship (Type, Print)					er, City or Town, State		
am 2 ther		Robert L. Allen/Son  20a. Method of Disposition	20b. Place of Dispo	osition (Name of		c., Kayn	nore, MO		
		1 Burial 2 □ Cremation 3 □ Removal from  4 □ Donation 5 □ Other (Specify)	cemetery, crei	matory or other place em. Park	11-		Woodlaw		
Department of Important: If any injury or once.	H	21. Signature of uneral Service Licensee	2 2	2. Name and Addres	ss of Facility W	lie F/t	1 P.A. 01	f Balto.	
8 5 5 8		20a Part 1. Enter the disease, or complication that c shock, or heart failure. List only one cause on e				<u> </u>		MD 21133	
Nedical and pricing and period an	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	(or as a consequence of):  (or as a consequence of):						
the	D	in the past 12 months?		□Ectopic pregnancy	,		23d. Date of Month	delivery Day Year	
attending p for use as	hysicia	1 Yes 2 Ho 9 Unknown 9 Unkn	own						
gned by the attending p be detached for use as	ed by Physician/M	THE ZEATHO OF LINKS			en in Part I.	23e. Did to	<b>\</b> /		
ate has been signed by the attending p page 2 should be detached for use as	Completed by	9 □ Unknown 9□ Unkn Part II. Other significant conditions contributing to d			na	1 Yes	res 2 No 3 an symmed? 24b. Were prior death 1 Y	Probably 4 Unkn	
ate has been signed by the attending p page 2 should be detached for use as	o Be Completed by	Part II. Other significant conditions contributing to d		anderlying cause giv	26. Place of De	1 Yas autop perfor 1 Yes eath (Check only or	res 2 No 3 an 24b. Were sy prior death 2 No 1 Y	Probably 4 □Unkn autopsy findings avail to completion of cause ? 'es 2 □ No	
this certificate has been signed by the attending paid inector, page 2 should be detached for use as	To Be Completed by	9 Unknown 9 Unkn	eath but not resulting in the u	nt 3 DOA Oth	26. Place of Deer:	24a. Was autop perfor 1 yes eath <i>Check only or</i>	res 2 No 3 an symmed? 24b. Were prior death 1 Y	Probably 4 \( \subseteq \text{Unkn} \) autopsy findings avail to completion of cause (? 'es 2 \subseteq \text{No}	
this certificate has been signed by the attending paid idector, page 2 should be detached for use as	To Be Completed by	25. Was case referred to medical examiner?  1 Yes 2 No 2 N	eath but not resulting in the u	anderlying cause given	26. Place of Deer: 4 \( \text{ Nursing } \)	24a. Was a autop perfor 1 Yes eath (Check only or 28d. Describe h	an 24b. Were prior med? death 1 Y 1 Y 2 No 1 The row injury occurred	Probably 4 \( \subseteq \text{Unkn} \) autopsy findings avail to completion of cause (? 'es 2 \subseteq \text{No}	
4 hours after death. Funaral Diractor: After this certificate has been signed by the attending p ely filled in by the funeral director, page 2 should be detached for use as	al Certification: To Be Completed by	25. Was case referred to medical examiner?  1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 28e. Place build  29a. Certifier (Check only 2 Medical Examiner: On the b	Inpatient 2 (XER/Outpatier of Injury At home, farm, string, etc. (Specify)	nt 3 DOA Oth M 28c. Injun Wor M 1 Dreet, factory, office	26. Place of De er: 4 \sum Nursing y at k? Yes 2 \sum No	24a. Was a autop perfor 1 Yes  eath (Check only or 1 Yes)  28d. Describe h  28f. Location (S City or Tow	an 24b. Were sy mred? death 1 Y 1 Y 1 Y 1 Y 1 Y 1 Y 1 Y 1 Y 1 Y 1	res 2□ No	
itler death.  Diractor: After this certificate has been signed by the attending p in by the tuneral director, page 2 should be detached for use as	Certification: To Be Completed by	25. Was case referred to medical examiner?  1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 28e. Place build  29a. Certifier (Check only 2 Medical Examiner: On the b	Inpatient 2 (XER/Outpatier of Injury and Injury At home, farm, string, etc. (Specify)	nt 3 DOA Oth M 28c. Injun Wor M 1 Dreet, factory, office	26. Place of Deer: 4 Nursing yat k? Yes 2 No	24a. Was a autop perfor 1 Yes  Path (Check only or Pecidon 1 Yes)  28d. Describe h  28f. Location (S City or Tow	an 24b. Were sy mred? death 1 Y 1 Y 1 Y 1 Y 1 Y 1 Y 1 Y 1 Y 1 Y 1	Probably 4 Unkni autopsy findings avail to completion of cause?  Yes 2 No  Specify)  Rural Route Number,  The state of the cause(s)	

State of Maryland / Department of Health and Mental Hygiene 0 0 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Year 790 M 2000 AGNES BROOKS MARY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mamaland General BALTIMORE CIT N/A 7. Age (In yrt. last birthday) Birthplace (State or Foreign Country) 5. Social Security Numbe 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. Director 88 220-30-4468 Aug 6 1918 VIRGINIA Usual Residence of Decedent with the Manyland 10a. State 10b. County 10c. City, Town or Location r than "naturel", or Iteme 23a or 28a-f ehow the Medical Examiner must be notified at 10d. Inside City Limits 1 X Yes 2 ☐ No MARYLAND BALTIMORE N/A Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 508 LAURENS ST. U.S.A. 21217 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5th grade HOUSEKEEPER PRIVATE other permit. Pages 1 and 2 should be file Deperment of Health and Mental Hy Important: If Item 27 is marked oth eny lighty or other treumatic event 2008. 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CORNELIUS HOOPER CORNELIA JORDEN 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cornelia A. Moseley/Niece 1116 Allison St., N.W., Wash., D.C., 20011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XX urial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ZION BAPT CHURCH 11-15-06 LOTTSBURG, VIRGINIA 21. Signature of Fun 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE, BALTIMORE, MARYLAND 21217 Part 1 Cafer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ethal **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sicien and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical phys the IF FEMALE: USB 23c. If yes, outcome of preg*nan*cy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ō Month Year Day 5 Other (specify) signed by the a P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 2 Probably 4 □Unknown es been signal 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page certificate 1 ☐ Yes 2 ☑ No Division of Vital 1 Yes 2 No Hospital or Attending Physician: funeral director 25. Was case referred to medical Be 26. Place of Death Check only one 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 🗌 Inpatient 2 ER/Outpatient this 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Mannes of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death thours efter death.

uneral Director; A 2 Accident investigation М 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours of To the Funeral Dicompletely filled in \*\*Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only To the 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month Day Year) 30. None and address of person who completed cause of death (Item 23a) (Type, Print) DiscHe Pac M.D. 31. Date filed (Month, Day, Year) NOV 1 3 2006 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

		For State Registrar	State of	Marylar		artmer			ınd M	ental Hyg	iene	006	35637
Physicia /Medic		Decedent's Name (First, Middle, L.  Nadine Gladys Bau	•							2. Date of Deat Month 11/9/0	Day	Year	3. Time of Death 9:30 p.m.
Examin		4a. Facility Name (If not institution, g.  Summit Park Reha	ve street and num			,		Location o		<u> </u>	4c. C	ounty of Death	h
Funeral Director		5. Social Security Number 214-20-4510 6.		7. Age (In yrs. 80	last birthday) Yrs.		r 1 Year	If Under 2 Hours		8. Date of Birth (Month, Day, 3/13/26	Year)	9. Birth	nplace (State or Foreign untry)  Aaryland
Maryland f ehow	ō	Usual Residence of Decedent  10a. State 10b. County  MD Howar	rđ		ty, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2√☐ No
with the Marylan 3e or 28e-f ehow	I Director	10e. Street and Number 6230 Sandrise Cou				10f. Zij	Code 1075			1		on of What Co	untry?
Sur Sur	by Funeral	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Dece Armed For 1 Tes If Yes, Give Year or Da	ces? 2×DXNo			dent of Hi cify Cubar	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecity Yes or No- Rican, etc.)	14	Black, White	
a stand 2 should be filed within 72 he fleath and Mental Hygiene. The fleath and Mental Hygiene. To then Tratum other traumatic event, the Medical	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 9th	Education rade completed) College (1-	4or 5+)		dent's Usu kind of wo DO NOT u	rk done d se retired,	ition uring most	of works	ng		of Business/I	industry
y ould	To Be C	17. Father's Name (First, Middle, Las Frederick Snyde	er					Lo	uise	(First, Middle, I	r		
permit. Pages 1 and 2 sh Department of Health and Importent: if Item 27 is n eny injury or other traum		19a. Informant's Name/Relationship  Bruce Bauer/Son  20a. Method of Disposition	(Type, Print)		_8549 [	Davis	Rd.	Col	umbi	J Route Number J MD 2.	1045	Town, State, Z	
mit. Pages partment of hordent: If its		1   Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Special Control Co	ify)	tate	cemetery, crem courridge	Memor.	al Pa	rk s of Facility	,	13/06			
Deparimingo Impo Inpo		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that ca	used the deal						eral Hor d., Flki r respiratory arm			
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)			quence of):	Lu	g	Can	cer				Onset and Death
	Examiner	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (d	or as a consec	quence of):								
ate be executed hysician and the burial-transit	Ical Exa	that initiated events resulting in death) Last	c Due to (d	or as a consec	quence of):								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		nth 2 ∐ Feta untat time of c	aldéath 3□	Ectopic p					23	d. Date of deli Month	very Day Year
w requires that been signed be should be determined by	ě	Part II. Dther significant conditions	contributing to de	ath but not res	sulting in the u	nderlying (	ause give	n in Part I.			es 2 🗆		the cause of death?
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nding Physician: The ath.	$\vdash$	27. Manner of Death  1 Natural 5 Pending 2 Accident investigati	28a. Date o (Month	f Injury n, Day Year)	28b. Time of Injury		28c. Injury Work		:	28d. Describe ho			лу)
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To the transfer of the transfe	×	29b. Signature and title of certifier  August 4,	Habiti	M. D			c. License		76			signed (Month	10, 2006
6		30. Name and address of person what ICaren L- Bab	/		m 23a) (Type, MC <sub>1</sub> 2		-						
Sta Registr		31. Date filed (Month, Day, Year)	32. <b>R</b> e	egistrar's Signa	ature	south	,						

			For State		State of Ma	arylan			of Heal			_	006	35638
			Registrar  1. Decedent's Name (I	First, Middle, Last)				imouto	0, 500		2. Date of Dea		Vana	3. Time of Death
	Physicia /Medic		Sophie	P	٨.		Brad	ford			Nonth NO V		Zoolo	10:30PM
	Examin	er	4a. Facility Name (If no	ot institution, give st	reet and number)	Oah	۵۲	4b. City, T	own, or Loca	tion of Death		. 1	inty of Death	-1
	Funeral		5. Social Security Num	nber 6. Søx	7. Ag	e (In yrs. I	AD ast birthday)	ff Under 1		nder 24 Hrs.	8. Date of Birt	HA		olace (State or Foreign
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	and		Usual Residence of De 10a. State 1	ecedent 0b. County		10c. City	, Town or Lo	cation					1	Od. fnside City Limits
	Maryl -f eho	tor	Maryland 1	Baltimore		D	undalk							1 □ Yes 2 XNo
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28e-f show ent, "Lie Medical Exardiner must be notified at	Funeral Director	10e. Street and Number	er				10f. Zip C	Code			10g. Citizen	of What Coun	ntry?
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	ter de Items	une	11. Marital Status  1 □ Never Married		<ol> <li>Was Decedent Armed Forces?</li> <li>1 ☐ Yes 2X</li> </ol>		S. 13. V	Vas Decede Yes, specif	nt of Hispani y Cuban, Me	ic Origin? (Spe ixican, Puerto	cify Yes or No- Rican, etc.)	14. F	Race - Americ Black, White,	
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-1 ehov eny injury or other traumatic event, it a Medical Examinar must be notified at once.			Cremation 3 □Re	moval from State	CE	emetery, crem View C	natory or oth	er place)	NOven	ber		on - City or To	
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			23a. Part1. Enter the shock, or heart for	disease, or complications. List only one	ations that caused cause on each li	d the death	. Do not ente	er the mode	of dying, suc	h as cardiac o	or respiratory an	rest,		Approximate Interval Between
	Physician		Immediate Cause (Fir disease or condition	-	Met	ast	atic	Dis	Seac	0,0	f Br	ain		Onset and Death
	/Medical Examiner		resulting in death)		Due to (or as	a consequ	ience of):	1	1 . (	) 12.	1	1	<	
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50	ding Ph h. After th funeral		27. Manner of Death 1 Natural	5 □ Pending	28a. Date of fnju (Month, Da	y Year)	28b. Time of fnfury		c. Injury at Work?		28d. Describe h	ow injury occ	curred	
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24	the H nin 24 the Fi	Medicai	one)	Medical Examine	and manner sta	ated.								
	or with or ha	2	29b. Signature and titl	e of certifier	10010			29c.	License num	ber	2	29d. Date sig	ned (Month, (	Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006 1 - For State Registrar Certificate of Death lent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4b. Examiner If Under 24 Hrs. last birthday) **Funeral** 1 M 2 K Director Town or Location with the Maryland 10c. City, Inside City Limits "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 Dio by Funeral Director Street and Nun 10f. Zip Oode 10g. Citizen of What Country? filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White etg." 11. Marital Status 1 ☐ Yes 2 ☐ → O If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 11 16 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give And of work done during ite. DO NOT use retired) 15. Decedent's Education fy only highest grade completed) 16b. Kind of Business/fndustry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any njury or other traumatic even" Elementary/S 0-12) Colfege (1-4or 5+) 's Name Sumame) Be Method of Disposition 2 Cremation /5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Part1. Enter the disease, or complications that caused it shock, or heart faifure. List only one cause on each line. roximate rval Betw Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Medical Certification; To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown contributing to death but not resulting is Part II. Other significant conditions underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 4 Unknown 245. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy certificate 2 No 1 ☐ Yes or Attending Physician: To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 200 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 CNatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours after To the Funeral Dire To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signatur 29d. Date signed (Month, Day, Year,

State Registrar 31. Date filed (Month, Day, Year),

State of Maryland / Department of Health and Mental Hygien [ ] [ ] 5 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street Examiner ANNE ARUNDEL 7. Age (In yrs. last birthday).
Yrs. If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Days Hours Months Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 27 is marked other than "natural", or Items 23e or 28e-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5-A 21 又 义 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1946 Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced MITE Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Las 18. Mother's Name (First, Middle, Maiden Surname) To Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) · PASADEMA, MD. Z1122 1945TROHUDR 20a. Method of Disposition
1 Burial 2 Cremation 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 0 3 Removal from State permit. Page Department of Important: If any injury or once. ANATOMY GIFTS REGISTRY 5 Other (Specify) H 4 Donation 22. Name and Address of Facility 21. Signature Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 Part I. Enter the disease, decomplica shock, or heart failure. List only one omplications that caused the Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): years /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Tes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b autopsy performed? 21 No 1 ☐ Yes 2 ☐ No 1□ Yes fo the Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: ္ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending death. 1 Tyes 2 □ No 2 Accident investigation hours after deat 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified November 7,2006 D-40521 Modelon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 325 HOSPITAL DRIVE SUITE 208 DR. O CHANEY STEN BURNIE, MD 21061 31. Date filed (Month, Day, Year) 32. Restrar's Signature State

DHMH 17 Rev 1/2001

Registrar

NOV 1 3 2006

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav 2006 November Done 11 Becoate 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Doctor's Community Hospital Lanham Prince Georges If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/24/1939 9. Birthplace (State or Foreign Country) South Carolina 5. Social Security Number 6. Se: 7. Age (In yrs. last birthday) Days 1X M 2□F 66 250-56-9192 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ty⊡Yes 2 □ No Maryland Prince Georges Bowie 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20720 11122 Lake Victoria Lane USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1X) Yes 2 □ No If Yes, Give Year or Dates! 56-193 1 ☐ Never Married 2X Married Specify: Black 1 ☐ Yes 2X No Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Driver Metro Transit Authority 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cobie Becoate Ella Blain 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11122 Lake Victoria Lane Bowie, MD 20720 Sadie Becoate/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/11/2006 Davidsonville, MD 21. Signature of Funeral Service 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final etasta disease or condition resulting in death) Due to (or as a consequence of): reuval Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nonknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy perform performed? 1☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation

Physician /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

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**Funeral** 

Director

Show r 28a-f show notified at

r than "natural", or items 23a or the Medical Examiner must be

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event.

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3altimore, Maryland 21215-0036

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attending physician for use as the buria Physician/Medical Certification: To

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Division or Vital Records, P.O. Box 68760,

or Attending Physician:

Hospital

State Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier Harron

2 Accident

3 Suicide

29a, Certifier

4 ☐ Homicide

6 ☐ Could not be

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 😾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

uck Rd.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

homas 31. Date filed (Month, Day, Year)

2006



State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Physician Year ZA beth NOVEMBER 6,2006 hon 9:47 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** RIVERVIEW CARE CENTER BALTIMORE ESSEX If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days Hours 1 □ M 2 □ X Director 90 216-66-3424 JULY 28, 1916 NC Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a. State 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 XYes 2 □ No MD BALTIMORE TURNER STATION Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 128 1/2 SOLLERS POINT ROAD 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ Specify: 3 XWidowed 4 ☐ Divorced BLACK Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) HOME MAKER HOME permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If Item 27 Is marked other i any injury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EDWARD HENDRIX OLIVIA GILLIAM ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA COCKRELL/DAUGHTER 128 1/2 SOLLERS POINT RD. BALTIMORE, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING MEMORIAL PARK BALTIMORE, MARYLAND 11-13-06 22. Name and Address of Facility  $JAMES \ A. \ MORTON \ \& \ SONS \ F.H., INC.$ 21. Signatule of Funeral Service Licensee ames of. 1701-31 LAURENS ST. BALTIMORE. 23a. Part/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** tteriosclustic bronary Ascolar Dheare 12008 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ deorcuta 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1004c 25. W s ase referred to medical examiner? 1∐ Yes 2 100 26. Place of Death (Check only one Other: 4 Hursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a e Funeral I 1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (wwwaring) D19667 11-07-2006 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) +508 Clea Brue May and 2001 Ritchie Hophung 1310 - annua ter 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

MAURO

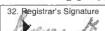
LMI

29b. Signature and title of certifier

NOV 1 3 2006

SARMIENTO

30. Name and odress of person who completed cause of death (Item 23a) (Type, Print)



10 CENTER DRIVE, BETHESDA, MARYLAND 20892

29c. License number

226513 - MA

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 5:32 A M 2006 Beverly Boltz Nov. 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Catonsville Baltimore Charlestown Care Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Hours 1 M 2 TF 053-14-8377 12, 1920 New York 86 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Catonsville Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 21228 USA 719 Maiden Choice Lane 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2X No White Specify. 3 ☐ Widowed 4 X Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 Bookeeper 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Florence Friedman Julis Rosenzweig 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117 19a. Informant's Name/Relationship (Type. Print) 12372 Greenspring Ave., Ownings Mills, Maryland Rhonda Kellner / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11/10/2006 | Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) Bavview Crematory 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Si natule of Euneral Service License 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) vn

Physician /Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trai Physician/Medical

Examine

**Physician** 

/Medical

Directo

Funeral

2

Completed

Be

ဥ

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

signed by to

þ

Division or Vital Records, P.O. Box 68760,

9 ☐ Unknown	9□Unknown		
Part II. Other significant condition	ns contributing to death but not resulting in the underlying cause given in Part I.    New   Section   New   New		se contribute to the cause of death?  ☐ No 3 ☐ Probably 4 ☐Ünknow
		24a. Was an autopsy performed? 1  Yes 2 No	24b. Were autopsy findings availab prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
DE Man coop referred to medical	OC Plane of De	oth (Chaok ank and)	

页		) requer me			1 ☐ Yes	2 No 3 Probably 4 Unknow			
Completed					24a. Was an autopsy performed?				
b	25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)				
0	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	□ER/Outpatient 3□	DOA Other: Nursing	Home 5 ☐ Residence	6 ☐Other (Specify)			
er unication.	27. Manner of Death  1. Natural 5 ☐ Pending  2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	3d. Describe how injury occurred			
	3 ☐ Suicide 6 ☐ Could not be determined		home, farm, street, fac sify)	28f. Location (Street City or Town, Sta	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
ממוכם		hysician: To the best of my kn aminer: On the basis of examin and manner stated.				(s) and manner as stated. and place, and due to the cause(s)			
2	29b. Signature and title of certifier	1 / -		29c. License number	29d. [	Date signed (Month, Day, Year)			

Il or Attending Physician: after death. I Director: After this certifica

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Doorecte 29d. Date signed (Month, Day, Year)

1 (6 06

Austelant Calculations M.

Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene? 1- State Amend item#26, perVerbal, 0861, 11/13/06 eTificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Virginia Elizabeth Boggs Month 5-30 PM 2006 NOVEMBER 08 /Medical 4a. Facility Name (If not institution, give street and number)
SAINT AGNES HOSPITAL 4c. County of Death N/A 4b. City, Town, or Location of Death Examiner BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 05/21/1916 5. Social Security Numbe 219–12–8995 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F 90 Yrs. Director Marylánd Usual Residence of Decedent 10c. City, Town or Location Maryland 10b. County rthen "natural", or Iteme 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits Howard Elkridge 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 6333 Beechfield Avenue 10f. Zip Code 21075 10g. Citizen of What Country? United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: δ 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygient Important: If Item 27 is marked other the eny injury or other traumatic event, Italy 2006. Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry D. Horner Estelle Barker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Orndoff/Nephew 6 Wheaton Drive, Littlestown, PA 17340 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial, 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Cemetery |11/13/2006 | Elkridge, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. Funeral Service Licensee 21. Signature muses 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE RENAL **Physician** FAILURE DAYS /Medical Due to (or as a consequence of): Examiner RHABDOMYOLYSIS DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) nding physicien and use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 | Fetal death 3 Ectopic pregnancy jo in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ed by the a 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 this certificate has been sign at director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No nerel Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Nation 2 □ ER/Outpatient 3 □ DOA Certification: To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ŏ To the Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) E. Sishnu Deepika P 20998 M.D. Nov - 08 - 2006 RI, St Agnes Hospital, 900 S. Caton Ave., BALTIMORE, MD-21229
32. Registrar's Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VISHNU DEEPIKA EVURI, 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

VIRGINIA

State of Maryland / Department of Health and Mental Hygiene 35646 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 9, 2006 **Physician** Ballard November 12:40 P M James Lincoln /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F 11, 1.03-09-5023 July 1916 Massachusetts 90 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. fnside City Limits 10a, State 10b. County i Health and Mental Hygiene. Item 27 is marked other than "natural", or Itema 23a or 28e-f ahow other traumatic event, the Medical Examinar minat be notified at 1 ☐ Yes 2 X No Director Bethesda Maryland Montgomery 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 20817 United States 6701 Tusculum Road Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ☐ Yes 2 📉 No fYes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Federal Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jennie Kingsley 2 James Henry Ballard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Elinor Ballard /Wife 6701 Tusculum Road, Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ō = 6 November 12, 1 ☐ Buriaf 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. Montgomery Crematorium, Inc Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Signature of Funeral Service Licenses Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01305 Carpest gelette 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part1. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical as the by the attending ached for use as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown ģ been signed by should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Diabetes Mellitus, Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 Probably 4 MUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Atrial Fibrillation, Hyperlipidemia, Dementia has autopsy performed? Yes 2 No certificate 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitaf: 1 ☐ Inpatient Other: 4K Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 ☒ No 2 ER/Outpatient 3□ DOA Director: After this in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 K Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours after within 24 hours a To the Funeral C Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier cal 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of ce 206 November 9, 2006 co pleted cause of death (from 2\$a) (Type, Print) e over Year) 32. Registrar's Signature State 2006 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 5/2 Linda Fisher Bowen 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Months Hours 1 □ M 2 🕅 F Yrs 212-66-9986 53 Maryland Director August 8, 1953 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits World 1 ☐ Yes 2 No Directo Maryland Montgomery Germantown rel', or Iteme 23a or 28a-f Examiner nesst be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20408 Watkins Meadow Drive 20876 United States by Funeral permit. Pages 1 end 2 should be filed within 72 hours after deat Department of Heelth and Mental Hygiene. Important: if them 27 ie marked other them any highry or other trainments. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Childcare Provider Child Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dewey Fisher, Jr. ပ Gwendolyn Wise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20876 Steven Todd Bowen / Husband 20408 Watkins Meadow Drive, Germantown, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State November 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State MontgomeryCrematorium, Inc 11, 2006 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc. 21. Signature of Funeral Service Licensee Ichselette Barnot M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset/and Death Immediate Cause (Final **Physician** Soust muni ( disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed physicien and s the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as attending | for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Tes 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s hes autopsy performed? certificete 1 ☐ Yes 2 ☐ No 1 Yes 2 1 NO 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1. Impatient ၉ 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital within 24 hours after death.
To the Funeral Director: Ah investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a Contifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 53(77 John Michael Waltmark tho completed cause of death (Item 23a) (Type, Print) MOR 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 13 Registrar 2006

DHMH 17 Rev 1/2001

ORIGINAL

	ian cal	Decedent's Name (First, Middle,		May E	Burkhai	ď				2. Date of Dear Month	Nov 08 Day Ember 7, 2	Year	3. Time of Death 8:00 p.
Exami		4a. Facility Name (If not institution,				4b. City,	Town, or	Location of	Death		4c. County	of Death	
			ederick Villa N							onsville		Balti	imore
uneral	П		6. Sex 1 □ M 2 x F		s. last birthday) Q8 Yrs.	If Under Months	Days Days	If Under 2 Hours	Min.	<ol><li>Date of Birth (Month, Day,</li></ol>	Year)	9. Birthpla Counti	ace (State or Fore
irector		220-46-6514 Usual Residence of Decedent	/ \		98 Yrs.					May 13,	1908	Α	Maryland
MO		10a. State 10b. County	-	10c. C	ity, Town or Lo	cation						10	d. Inside City Limi
1	ţ	Maryland	Baltimore				C	atonsvill	ρ.				1   Yes 2
128	Director	10e. Street and Number				10f. Zip		4101104111		1	Og. Citizen of \	Whal Countr	ry?
238	0 8	1012 Hartmont Rd.						212	28			U.S.	A.
of other than "natural", or liems 23a or 28a-f show event, the Madical Examiner must be notified at	Funeral	11. Marital Status	12. Was Dece Armed For		U.S. 13.	Was Deced	denl of Hi	spanic Orig	in? (Spe	cify Yes or No- Rican, etc.)		e - America	
호를		1 Never Married 2 Marrie		2 No	1	1 ☐ Yes 2	- /	Specify:	ruerto r	nican, etc.)		ck, White, et	tc.
E	d b	3 Widowed 4 □ Divorced	Year or Da	ites:		10103 2	2120	Зреспу.			Specify	v: V	Vhite
adica adica	Completed by	15. Decedeni's (Specify only highest	s Education grade completed)		(Give	dent's Usua kind of wor	rk done d	uring most	of workir	ıg .	16b. Kind of Bu	usiness/Indu	ustry
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other then		17. Father's Name (First, Middle, L	251)				Hor	nemake		(First halidate h			
	Be							18. Mother	s Name	(First, Middle, A		•	
s mark umatic	2	19a. Informant's Name/Relationshi	n Vordember	ge	401 14 111						erine Fis		
7 ls m traum			, , , , , ,		m.					Route Number,		State, Zip C	Code)
item 27 is marks other traumatic		Ms. Katherine B. Sh 20a. Method of Disposition	atzer Da	ughter	Place of Dispo			t Rd. Ca		ille, Marylaı		C: T	
= 5		1 Burial 2 Cremation	3 □Removal from S		cemetery, crer	natory or of	ther place	)			Oc. Location -		
ntan Picy		4 Donation 5 Other (Sp.				Ridge C			11/1	3/2006	Pike	esville, M	/laryland
Important: If item 2 eny injury or other once.		21. Signature of Funeral Service L	Censoo	W	22			s of Facility uneral I	Home	РΔ			
		23a. Part1. Enter the disease, or c shock, or heart failure. List o	ica nut	INFOIS	-93	3	3871 C	ld Colu	mbia F	Pike Ellicott	City, MD	21043	
d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (c	or as a consec	quence or):							1	
sicien en e burial-tr	cal	resulting in death) Last	c. Due to (d	or as a consec	quence of):								
I by the attending physicien end stached for use as the burial-transit	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d	come of pregn rth 2 ☐ Feta ant at time of c	ancy al death 3 death 5	Ectopic pre	ecify)	(1.5)			23d. Dati Mor	e of delivery nth Da	ay Year
gned by the attending be detached for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	d	come of pregn rth 2 ☐ Feta ant at time of c	ancy al death 3 death 5	Other (spe	ecify)	n in Part I.			Mor	nth Di	
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Director: After this certificate has been signed by the attending I in by the funeral director, page 2 should be detached for use as	ertification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d	patient 2	ancy al death 3 death 5 sulling in the ur  DER/Outpatien 28b. Time of Injury ome, farm, stre	Other (special deriving call d	A Other	26. Place o	ing Hom	1  Yes  24a. Was an autopsy perform 1  Yes 2  (Check only one	Moracco use contribution of the second of th	nith Distribute to the 3 Probab  Vere autops: rior to compleath? Probab  Probab  Vere autops: rior to compleath? Probab  Prof (Specify)	cause of death?  cause of death?  cylindings availabletion of cause of
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			For State Registrar		State o	of Marylan	d / Depa <i>Ce</i>	artment rtificate	of H	ealth a Death	and M		giene	006	356	49
	*		1. Decedent's Nam	ne (First, Middle, La	ist)							2. Date of De Month	ath Day	Year	3. Time	
	Physici /Medi		John W	. Booze								CKTOBO	,	31 200	6 4:0	O PM
	Examir		4a. Facility Name (	'If not institution, giv	e street and nu			-		Location of			4c. C	ounty of Dea	th	
				SAMAR		HOSP17.				If Under						
	Funeral Director		5. Social Security 1 212-03-0		Sex 1XIM 2□F	7. Age (In yrs. 96	iast <i>birtnd</i> ay) Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Mar 29	tn y, Yea <i>r)</i> 1010	9. Bir	thplace (State ountry)	or Foreign unk
			Usual Residence of			90						rial 29,	1910	,		
	yland		10a. State	10b. County		10c. City	y, Town or Lo	cation							10d. Inside	City Limits
	e-f	ctor	MD	Baltin	nore		Tows	on							1 ☐ Ye	s 2X No
	with the Maryland a or 28e-f ahow be notified at	Oire	10e. Street and Nu	mber				10f. Zip	Code				10g. Citize	on of What Co	ountry?	
	death with the Maryland ms 23a or 28e-f show r mast be notified at	Funeral Director	8710 Emg	ge Road	· · · · · · · · · · · · · · · · · · ·					1204				USA		
	er de	nne	11. Marital Status		Armed Fo		.S. 13.	Was Deced If Yes, spec	ent of Hi fly Cubai	spanic Ori n, Mexican	gin? (Spo 1, Puerto	ecify Yes or No Rican, etc.)	- 14	<ol> <li>Race - Ame Black, White</li> </ol>		
36	rs aft	by F	1 ☐ Never Man 3 🛣 Widowed	ried 2 Married	1 ☐ Yes If Yes, Gi Year or [	ive		1 ☐ Yes 2	X No	Specify:			s	pecify: W	hite	
215-0036	72 hours after natural', or ite	ed		15. Decedent's E	ducation		16a. Dece	dent's Usua	I Occupa	ition		unk	16b. Kind	of Business	/Industry	unk
215	드 - 교육	Completed	(Spe	cify only highest gr	ade completed)	1-4or 5+)	(Give	kind of wor DO NOT us	k done d	uring mosi	t of work	ng			,	ann
212	d withir giene. er then	mo;	unk	, , ,	ınk	1-401 37)										
Pu	al Hygid d other	Be (	17. Father's Name	(First, Middle, Las	")			unl	c	18. Mothe	er's Name	(First, Middle,	Maiden S	umame)		unk
<u>y</u>	Ment Ment	ပ													_	
Maryland	permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other treumatic event, ILaA 2016.			lame/Relationship				-				il Route Numbe			Service 1	
	and Health Im 27			artian H	ospital	20h P	ace of Dispo			Raven		d Balti				
Baltimore,	it of H			☐Cremation 3			emetery, crei	natory or of	her place	e)		Jale	20c. Loca	tion - City or	Town, State	
ţ	t. Pa rtmen rtant: rjury			5 X Other (Speci			T. e.			1-						
Bal	permit. Departr Imports any inj		21. Signature 1	oneral Service Lice	Wade,	irector						655 W.	Balt	imore	Street	
			23a Party Enter	the disease, or con	polications that	caused the death		ltimo					rrast		Approxima	ıte.
			shock, or hea	art failure. List only	one cause on	each line.			_						Interval Be Onset and	tween
May	Physician /Medical		disease or condition resulting in death)	on	a. VE	(or as a consequ	LLAY	- <i>F</i>	13,	RILL.	AT	WN				
	Examiner			- 1	Due to	(or as a consequ	uence of):	.3	1+2	00 -	-	FALL	140			
	A TOTAL	ē	Sequentially list confidence in any, leading to it cause. Enter Under	onditions, mmediate	b. Due to	(or as a consequence or a conseque	uence of):		110	( pm	0	AY 274 A	11 (-	1	-	
	be executed sician and burial-transit	Examiner	Cause (Disease or that initiated event	rinjury	c.					O	~ 1	11001(1)	eer	,		
oʻ	an an rial-tr		resulting in death)	Last	Due to	(or as a consequ	uence of):									
8760,	cate be execut physician and the burial-trar	dical			d											
9		Med	IF FEMALE:					<del></del>								
Вох	The law requires that the death certificate has been signed by the ettending I age 2 should be detached for use as	by Physician/Me	23b. Was deceder		1☐Live t	tcome of pregna pirth 2 Fetal	death 3	Ectopic pre					23	d. Date of del	ivery Day	Year
	the e	/sici	1 Yes 2	□No	4∐Pregi 9∐Unkn	nant at time of de lown	eath 5□	Other (spe	ecrfy)					NOTE	Duy	1 001
P.0	thet the de ed by the e detached f	P	Part II. Other signi		contribution to d	leath hut not resu	ulting in the u	nderlying ca	uisa diva	n in Part I		23e Did to	nhacco use	contribute to	the cause of	death?
Division of Vital Records,	signe d be	by	. until entities original	PROSTI	_	CANO	_	noony ing oa	1436 g110	iiiii r okiti.			res 2 🔽		obably 4	
Ö	w requir been si should	etec		, , , , , , , , , , , , , , , , , , , ,												_
3ec	sician: The law certificete has t rector, page 2 s	Completed		11 24	EMER	J Di	SUFFI	6-				24a. Was autop		prior to death?	itopsy findings completion of	cause of
<u>a</u>			25 101									1 Yes	250 No		2 🗆 No	
₹	Physician: this certific ral director,	o Be	25. Was case refe examiner?		Hospital:	Innestinat OP	ED/O		Othe			Check only o		7		
ō	Phys r this aral di	: To	1 Yes 2 2 27. Manner of Dea		28a. Date	Inpatient 2, 2, of Injury	28b. Time of		Bc. Injury Work	at A LI NU	rsing Hoi	me 5 Resid	now injury o	_JOther (Spe	cify)	
0	Attending Ph ir death. ector: After th by the funeral	it o	1) X Natural 2 ☐ Accident	5 Pending investigation		nth, Day Year)	Injury	м		? ′es 2 ∐ i	No					
N N	el or Attendir safter death. I Director: Af d in by the fu	100	3 Suicide	6 Could not be determined	280. Place	of Injury - At ho	me, farm, str	eet, factory,	office			28f. Location (S	Street and I	Number or Ru	ıral Route Nur	n <i>ber</i> ,
Ö	s afte	Certification:	4 [] Northclub		build	ing, etc. (Specify	<i>'</i> )					City or Tov	vn, State)			
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edicai (	29a. Certifier (Check only	1 Certifying P	hysician: To the	e best of my know	wledge, deatl	n occurred a	it the tim	e, date and	d place, a	and due to the	cause(s) ar	nd manner as	stated.	5)
	To the P within 24 To the F complete	Med	one) 29b. Signature and		and man	ner stated.				number						-/
	T V I	-	250. Signature and	ATT	NDING	PHY	SICIAN				1 ) 3<			signed (Mont		72656
									00		100	7 /	0 0000	LIDE YE	<i>d</i> (	6200
			30. Name and add	ress of person who	completed caus	se of death (Item	23a) (Type,	Print) M	AU	7	J 11 ( )	19 X	5 6	7 2	ara	
	Sta	te.	31. Date filed (Mor			Registrar's Signa	ture	) [][	27 17	11/12	1	DFIL (	11/4/1		·	
2.5	Regist			1 1 3 200			Long	20								

DHMH 17 Rev 1/2001

06-08267 Diane Berry Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No. Registrar Decedent's Name (First, Middle, Last) Date of Death Physician/ Month Day November 1, 2006 Medical Examiner 1557 hrs Diane E. Berry 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Bayview Hospital 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or Foreign **Funeral** Country' Months Davs Director Hours 220-38-6002 1 M 2 **X**F 65 Oct 19. 1941 Maryland Usual Residence of Decedent 'n 10a State 10b County 10c. City, Town or Location 10d Inside City Limits Yes 2 No 28a-f show MD Baltimore death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 5703 Benton Heights Avenue 21206 USA l", or items 23a c ner must be notif Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 X Married Yes 2 X No Widowed Divorced If Yes, Give Year 1 Yes 2X No specify: Specify: white þ 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Larges I and 2 should be filed within 72 hou. trament of Health and Mental Hygiene. Tant: If item 27 is marked out or other trament. Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 barmaid 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Carroll Joseph Hildebrand Valerie Dauterich 19a. Informant's Name/Relationship (Type, Print.) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ပ Glen Berry/spouse 5703 Benton Heights Avenue Baltimore, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State Important: I 4 X Donation 5 \_\_\_ other Specify grand Service Licensee 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street That caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart art I. Enter the disease, or complications Approximate Interval Physician failure. List only one cause on each line /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X UNPENDED AMENDED. item#23a,27,perME,g861,11/21/06 TI Division of Vital Records, P.O. Box 68760, IF FEMALE: phys the b 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Month Day Year 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I ⋧ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has t performed? death? After this certificate page ✓ Yes 2 1 🗸 Yes 2 No 26 Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical Be Hospital: 1 Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 Other 1 V Yes 2 28c. Injury at Work? 27. Manner of Death 28a, Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 X Natural Pending Yes 2 No hours after death. within 24 hours after death To the Funeral Director: Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number O.C.M.E. November 2, 2006 ed cause of death (Item 23a) of person who comple Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State mile) Registrar

DHMH 17 Rev 1/2001 OCME 2006

			State of Maryland / Department of Health and Mental I  1 - State Registrar Amend #20b Per FH G861 11/13/26/iff Late of Death	Hygiene Reg. No.2006	35651
			Decedent's Name (First, Middle, Last)     2. Date o	f Death	3. Time of Death
	Physici /Medic		WILLIAM FLOVD CRUDUP NOV	Day Yea	6 4:25 AM
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	4c. County of De	
F			GILCHRIST HOSPICE BALTIMORE	N	IA
ı	Funeral Director			, Day, Year)	Sirthplace (State or Foreign Country)
2.	D		Usual Residence of Decedent  MARC	2H 11, 1944 NO	ORTH CAROLINA
	arylan show d at	_	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	he M 28a-f	Director	MAKY/AND N/A CALTIMORE ()  10e. Street and Number 10f. Zip Code	TY	1 Ø Yes 2 No
	with yard	į	10e. Street and Number 10f. Zip Code	10g. Citizen of What (	Country?
	death ms 2: mus	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or	r No- 14. Race - Ar	nerican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highty or other traumatic event, the Medical Examiner must be notified at once.	by Fur	Armed Forces?  1 □ Never Married 2 Married  1 □ Yes 2 No  1 □ Yes 2 No Specify Cuban, Mexican, Puerto Rican, etc.  1 □ Yes 2 No Specify:	) Black, Wr Specify: //	ite, etc.
21215-0036	72 hou natura ical E	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working	16b. Kind of Busines	s/Industry
21	within 7 ene. than "r he Med	nple	Elementary/Secondary (0-12) College (1-4or 5+)		0
	filed w Hygier ther th	S	10 TH GRADE DEPT. OF RECREATION + PARK		= BALTIMORE
and	should be filed withir and Mental Hygiene. marked other than matic event, the M	Be c	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)  19. Mod J J F	idie, Maiden Surname)	11/2001
Maryland	should and Men s marke umatic	P_	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number of Rural Route Numbe	umber, City or Town, State	Zin Code)
_	if and 2 is Health ar tem 27 is		VERTIA M. CRUDUP (WIFE) 3425 FLMLEN AVE. E	BAITIMORE	EMDZIZI3
ore,	es 1 a of He of He fitem	1	20a. Method of Disposition  20b. Place of Disposition (Name Connectory)  Date	20c. Location - City of	
Ĕ	Pages ment of l ant: If its ury or o	١.,	4 Donation 6 Other (Specify)	BALTIME	ORE HARYLAND
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of run-tal Service Line name 22. Name and Address of Facility BROWN JOSEPH H. BROWN	BALTO, M.	RAL HOME
	F.		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator shock, or heart failure. List only one cause on each line.		Approximate Interval Between
	Physician	ì	Immediate Cause (Final disease or condition		Onset and Death
4	/Medical Examiner		resulting in death)  Due to (or as a consequence of):		900
	A P A	-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
	nsit	Examiner	Cause (Disease or injury		Ī
Ć	execuin and ial-tra	Exa	that initiated events resulting in death) Last c		
58760,	icate be executed physician and the burial-transit	dical	d		
			IF FEMALE:		
Box	death ce	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No  23c. If yes, outcome pt pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)	23d. Date of do Month	elivery Day Year
P.O.	at the	Phy	3 LI OTIKNOWN		
Division or Vital Records,	The law requires that the death certific ten has been signed by the attending page 2 should be detached for use as	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	oid tobacco use contribute  Yes 2 □ No 3 □ F	to the cause of death? Probably 4 □Unknown
ec	law ras be	Completed	24a. W		autopsy findings available ocompletion of cause of
E F	r: The	Co	p. 1□ Ye	erformed?   death?	s 2□No
Zit.	sician certifi rector	Be	25. Was case referred to medical examiner?  1  Yes 2 No Other: 4 Department 2 DER/Outpatient 3 DOA Other: 4 Department 4 D	<del></del>	
ō	Physer this eral di	- To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Descri	Residence 6 Souther (Sp libe how injury occurred	ecifyΝρίφ
ion	nding th. r: Afte e fune	atior	1	ar man mjary occanica	
Vis	r Atte er dea recto by th	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Locatio City or	on (Street and Number or F Town, State)	Rural Route Number,
	ital o				
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to a place, and due to a place. The basis of examination and/or investigation, in my opinion, death occurred at the time and manner stated.	the cause(s) and manner a me, date and place, and du	as stated. ue to the cause(s)
	To the comp	ž	29b. Signature and title of certifier 29c. License number	29d. Date signed (Mor	nth, Day, Year)
	1		V58303	November	10 2006
0			29b. Signature and title of certifier  D58303  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  AMON CURCUS MO 6565 N - Warder SY, Baltone ( 31. Date filed (Month, Day, Year)  NOV 1 3 2006	WD.21204	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature		
	Registr	ar	NOV 1 3 2006 Deaus St. Agreet		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 29d per doc 8861 11-13-06 vt

		for State Registrar		iryland / I		ificate of	Death			Reg. No.	2006	356	552
Physi	cian	1. Decedent's Name (First, Middle, La	ast)					2	2. Date of De	eath Day	/ Year	3. Time of [	Death
/Med		GLADYS	COTTM	AN					Novemb	er 2	2006	2:30	a <sup>M</sup>
Exam	iner	4a. Facility Name (If not institution, given			4	4b. City, Town, o				4c.	County of Dea		
Funera	21	3711 COURTLEIG  5. Social Security Number 6.5		e (In yrs. last bii		RANDAL If Under 1 Year	If Under 2	4 Hrs. 8	B. Date of Bir	rth	9. Bir	TIMORE C thplace (State or	
Directo		077-22-3514 Usual Residence of Decedent	1 □ M 2ÅQXF	95	Yrs.	Months Days	Hours	Min.	(Month, Da IAR 31			ountry) YLAND	
yland Iow at		10a. State 10b. County		10c. City, Tow	n or Locat	tion						10d. Inside City	y Limits
a-fsh	ctor	MARYLAND BALTI	MORE	R	ANDAI	LLSTOWN						1 ☐ Yes	2 <b>∏X</b> No
ith the or 28 e not	Director	10e. Street and Number				10f. Zip Code				10g. Citi	zen of What C	ountry?	
ath w	rall	3711 COURTLEIGH	<del></del>		1	2113					J.S.A.	S. L. P.	
ter de item: ner n	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐XN		13. Wa	as Decedent of H /es, specify Cuba	an, Mexican,	Puerto Ri	ity Yes or No ican, etc.)	o-	14. Race - Ame Black, Whi		
urs af al", or Exami	Ş	3 ⅓Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 🗆	JYes 2∭XNo	Specify:				Specify: BL	ACK	
IOTE, INICITY STATE A LATE 13-0030 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the M dical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a	(Give kin	nt's Usual Occup	during most (	of working	7	16b. Ki	nd of Business	/Industry	
Marylatio ZIZIS 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than " traumatic event, the Mod	mple	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DO	NOT use retired	d)		,				
Hygie ther t		unknown 17. Father's Name (First, Middle, Las	t)		_DOME	ESTIC	18. Mother	's Name (	First, Middle		ELF Surname)		
d be d be ded o	To Be	JOHM CHAMPION	7					,	OWELL	,			
shoul mark	-	19a. Informant's Name/Relationship	(Type. Print)	198	o. Mailing /	Address (Street				er, City o	r Town, State,	Zip Code)	
e, INIC 1 and 2 Health a tem 27 is		Audrey Couser/Gr	andaughter		3711	Courtle	eigh Dr	c., R	Randal.	lstov	vn, Md.	, 21133	
of He		20a. Method of Disposition 1 XXurial 2 □ Cremation 3 [	Removal from State	20b. Place o cemete	f Dispositi ery, cremai	ion (Name of tory or other plac	ce)	Da	te	20c. Lo	cation - City or	Town, State	
Dallillor bermit. Pages Department of I mportant: If its any injury or o		4 □Donation 5 □ Other (Speci	ify)	DRUID	_	GE CEMET			7-06	BALT	TIMORE,	MARYLAN	ID .
Dallinore, permit. Pages 1 an Department of Heal Important: If item 2 any injury or other		21. Signature Funeral Service Lice	ensee		WII	Name and Addre	BROWN	COMM	MUNITY	FUNE	ERAL HO	ME P.A.	
		23a. Parti. Enter the disease, or con shock, or heart failure. List only	nplications that caused	the death. Do		06 W NOR the mode of dvir			respiratory a	ırrest.		Approximate Interval Betw	
Physicia		Immediate Cause (Final	one cause on each lin	10.	ASTI	/ ( Na)	DIMA	M A				Interval Betw Onset and D	eath
/Medica		disease or condition resulting in death)	a	>1 ALD 1	14/16			101	79 1-			101512	006
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Examine		Sequentially list conditions	b			C CAN	NAC	Car	VITY	,		To ulila	100 b
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	a consequence		Domo	NAL	CAI	VITY	,		To ulila	LO8 6
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icate be executed physician and sthe burial-transit	ledical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a	a consequence	of):	>Domo	NAL	CAI	NITY			70 U/1/2	208 6
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			For State Registrar	State of Maryla		artment of H rtificate of L			giene Reg. No.	106	35653
	Physici	an	Decedent's Name (First, Middle, Las	Childs				2. Date of Dea Month	Day	Year	3. Time of Death  5:50 PM
V	/Medic	al	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of De	Alverte	<del></del>	2006 v of Death	3:10 FW
	Funeral Director	er	230 Constant Ave  5. Social Security Number 6. Security Number 11  218-30-4444  Usual Residence of Decedent	ax □ M 2뒃 F 7. Age ( <i>ln yr</i>		Severn If Under 1 Year Months Days	If Under 24 H Hours Mi	rs. 8. Date of Birt	Ann h /, Year)	e Arui 9. Birthpi Coun West	lace (State or Foreign try) Virginia
	ehow	7	10a. State 10b. County		City, Town or Lo	cation				10	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	vith the N t or 28a-f	Directo	Maryland   Anne Arum 10e. Street and Number	ndel Sev	ern	10f. Zip Code			10g. Citizen of	What Coun	
	ne 23e	Funerai	230 Constant Ave	12. Was Decedent Ever in	U.S. 13.	21144 Was Decedent of Hi	spanic Origin?	(Specify Yes or No-		ce - Americ	
920	be filed within 72 hours after death with the Maryland ital Hygiene. I have so ther than "naturel", or Iteme 23a or 28a-f show event, the Medical Examiner must be notified at		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:		fYes, specify Cuba 1□Yes 24,□No	n, Mexican, Pui Specify:	erto Hican, etc.)	Speci	ack, White, o ty: Wh	nite
2-0	72 ho	eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	dent's Usual Occupa	during most of w	vorking	16b. Kind of E	Business/Inc	dustry
121	e filed within al Hygiene. other then " vent, the We	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)		- Employe			Sales		
bu	be filed tal Hygi d other	Be C	17. Father's Name (First, Middle, Last)		, , , , , , , , , , , , , , , , , , , ,	TIMP TO YO		ame (First, Middle,		me)	
Zla	2 should be and Mental is marked (	인	Ralph Caldwell				Ada Wo	<del>-</del>			0.11
Ma	s 1 and 2 should f Health and Men item 27 ie marke other traumatic		19a. Informant's Name/Relationship (7) Sheila Spurlin- da			e in in the		Rural Route Numbe	and the ter	255-2000	Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other tra once.		20a. Method of Disposition  1 Table 12 Cremation 3	Removal from State	. Place of Dispo cemetery, crei	sition (Name of matory or other plac	e)	Date	20c. Location	- City or To	
ıtim	artmen artmen ortant: injury		4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Funeral-Service Licen			Memorial E			Elkridg		
B	Dermi Depa Impo eny is		21. Signature of Funeral Service Licen  23a. Part 1. Enter the disease, or compshock, or heart failure. List only of the product of the composition of the compositio		G 7	ary L. Ka 250 Washi	ufman F	uneral Ho	ome at l	MMP,	INC.
ı			23a. Part1. Enter the disease, or composhock, or heart failure. List only	ofications that caused the de one cause on each line.	eath. Do not ent	er the mode of dyin	g, such as card	iac or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a cons	Mary	Jeps	ک				
	Examiner		Sequentially list conditions,	b Me	testat	ic Ch	olang	io Carcir	noma		
	ed sit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):		/				
Ć	cate be executed physicien and the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as a cons	equence of):						
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P.O. Box 6	ne death certifi the attending thed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Theo	23c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ Fo 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)				ate of delive	ny Day Year
S, D	s that the	by Pt	Part II. Other significant conditions of	ontributing to death but not r	esulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use cor	ntribute to th	e cause of death?
ord	w requires that s been signed E should be deta	ted	Mamner	tun				1 🗆 Y	'es 2□No	3 Prob	
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tal	ician: Th certificete rector, pag	a)	25. Was case referred to medical				26. Place of D	1 ☐ Yes eath (Check only o	2 No	1 🗆 Yes	21XNo
∑ <		ToB	examiner? 1 Yes 2 XNo		☐ ER/Outpatie		4   Nursing	Home 5 Resid			1)
Division of Vital Records,	To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		28b. Time o Injury	Worl	/ at <br Yes 2 □ No	28d. Describe h	low injury occu	rred	
Divi	s after del Direct	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, st ocify)	reet, factory, office		28f. Location (S City or Tow	Street and Num m, State)	iber or Rura	l Route Number,
	Hospi 24 hour Funer etely fill	Medicai		ysician: To the best of my land manner stated.							
	To the Ivithin 24	¥.	29b. Signature and title of certifier	7 1 -1		29c. License			29d. Date sign	ed (Month, I	Day, Year)
•	10		30. Name and address of person who	completed cause of death (I	tem 23a) (Tyne		57659	7	71	17/	06
-	1		Samuel &	Bieligh	, MD	305 +1	ospita	Diin	hien B	mil	ms 2/06/
	Sta Regist		31. Date filed (Month, Day, Year)  NOV 1 3 2	32. Registrar's Sig	gnature						
DH	HMH 17 Rev 1/2	001		J. S. Michigan	15	SINIA!		<del></del>			
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Examiner  4a. Facility Name (If not institution, give street and number) 9322 Mellenbrook Road.  5. Social Security Number 498-20-9244  1 M M 2 F 90 Yrs.  4b. City, Town, or Location of Death Columbia  Howard  5. Social Security Number 498-20-9244  1 M M 2 F 90 Yrs.  4c. County of Death Howard  Funder 1 Year If Under 24 Hrs. Months Days Hours Min. Min. Min. Aug. 21, 1916  9. Birthplace (State or Foreign Months, Days Hours Min. Aug. 21, 1916  1 Director  9. Birthplace (State or Foreign Months, Days Hours Min. Aug. 21, 1916  1 Douisiana				1 - For State Registrar	State of Ma	arylan		artment of F rtificate of			ntal Hy	giene Reg. No		35654
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Security of personal residence of personal residence of personal p				Lester L. Ci	convich					N		er 8		11:45 P M
Second Secondary County   The Proposed Part	1							4b. City, Town, o	r Location	of Death		4c	. County of Death	
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Physician / Medical Examiner  23a. Part. End the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Fig. List only one Subset and Death State of Death (Section 1) and the cause of Death (Section 1) and the caus	more	Pages 1 ent of Hi nt: If Iter ny or oth		1 ☑ Burial 2 ☐ Cremation 3 ☐				-					•	
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Physician Medical Examiner    The content of the co		_		23a, Part1, Enter the disease, or com	plications that caused	the death							la, Mary	
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29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and didress of person who completed cause of death (Item 23a) (Type, Print)	n	ding l	lon	1 ☑Natural 5 ☐ Pending		Year)					Describe I	now injur	ry occurred	
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		•	For State of Maryland / Dep	artment of F ertificate of I			gienez () (	16	35655
			Registrar  1. Decedent's Name (First, Middle, Last)	Timodio or i		2. Date of Dea	ath		3. Time of Death
	Physicia /Medic		MARIE E. COOK			NOV.	7 200	Year 06	8:20P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	Location of Death		4c. County o		
			6814 Eastbrook Avenue		ltimore If Under 24 Hrs.	0 D-1/ Dia	Baltim		
	Funeral Director		5. Social Security Number  218 • 58 • 3283  6. Sex  1	Months Days	Hours Min.	8. Date of Birt (Month, Da)		9. Birthp Coun Marsu	lace (State or Foreign try) Land
			Usual Residence of Decedent			June 1	8,1952	inar y	Tariu
	nylan how		10a. State 10b. County 10c. City, Town or I	ocation				11	Od. Inside City Limits
	8a-f	octo		timore Ci	ty				1 Ves 2 No
	with the	Funeral Director	10e. Street and Number	10f. Zip Code 212	2.4		10g. Citizen of WI	nat Coun	itry?
	leath	era	6814 Eastbrook Avenue  11. Marital Status 12. Was Decedent Ever in U.S. 13			ecify Yes or No-		- Americ	an Indian,
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Heath and Mental Hygiene. Deperment of Heath and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examir at must be notified at once.	Ď	1 Never Married 2 Married In Yes 3√2XNo If Yes, 3√	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes ※X No		Rican, etc.)	Specify:	, White, o	etc. nite
ָ כ	72 ho natur	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occup e kind of work done o DO NOT use retired	ation during most of work	ing	16b. Kind of Bus	iness/Ind	lustry
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0	id be ental ked o	To Be	Calvin Rosenthal		Marie	Buettn	er		
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рани	permii Deper Impor eny ir		21. Signature of Funeral Service Licensee	22. Name and Addres Lassahn 7401 Bel	Funeral L Lair Ro. E	lome Saltimor	re, Md. 2	21236	3
			23a. Part1. Enter the disease of complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
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cords, r	w requires that the death cer been signed by the attendin should be detached for use	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause giv	en in Part I.	23e. Did to			e cause of death? ably 4  Unknown
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<u> </u>	the table to be page	Con	NAME			perfor 1 ☐ Yes	rmedi? de	ath?	2100
VIII	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	ont all pos Oth	26. Place of Death	. /			,
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5	ital or irs afti ral Dli led in				73				<u> </u>
	To the Hospital or Attending Physician: The law within 24 hours after deadh.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deal of the best of the best of the best of the best of the best of the best of my knowledge, deal of the best o	th occurred at the tin nvestigation, in my o	ne, date and place, pinion, death occurr	and due to the ded at the time, o	cause(s) and mand date and place, an	ner as sta d due to	ated. the cause(s)
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			et. Seleasallan M	DD	4553	00	11-08	3-0	2006
	$\sim$		30 Name and address of person who completed cause of death (Item 23a) (Type	, Print)	La Dag	D (1	NITERN	5 A	1021237
			31. Date filed (Month, Day, Year)  32. Begistrar's Signature	LA DE P	mit kot	+1) 120	JITE AU	0 110	1021-01
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Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

Julie Amanda Co		I- For State	Sta	te of Maryla		rtment of		Menta	al Hyg		eg No	200	16	356	56
Physicia		Registrar 1. Decedent's Name	e (First, Middle,	Last)		-			2	Date of Dea	ath	UI	3. T	ime of Death	~
Medical Examin	1111	Julie An								Month Novembe	r 1, 2006	Year	2	000 hrs	
1		4a. Facility Name (if			mber)	Ţ.	4b. City, Town, or L	ocation of				unty of De	eath		
1		522 East Ala	abama Ave	nue Apt. E			Salisbury				Wice	omico			
Funeral		5 Social Security N	umber 6	. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under		8. Date of Bi	rth (MM/DD/)	YYY) 9	Birthplac	ce (State or For	eign
Director		471-44-27	784	1 M 2 XF	68	Yrs	Months Days	Hours	Mın.	Sept	14, 19	38		York	
	ŀ	Usual Residence of	Decedent												
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ifter of all, o	Dy F	3 Widowed	4 Divor	ced If Yes, Give Yea		1	Yes 2 X No	specify:			Spe	cify wh	ite		
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Baltimore, MD 21215-0036  permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu	neral Service L onald S	Waden	Director	22. N S t	lame and Address ate Anato ltimore,	of Facility	oard	.655 W	. Balı	imoı	re Si	reet	
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Division of Vital Records, P.O. Box 68760, in 24 hours alter damped by sician: The law requires that the death certificate be executed the Anours after death. After this certificate has been signed by the attending physician and natletely filled in by the funeral director, page 2 should be detached for use as the burial - transit	edical	X UNPENDED		d											_
O, e be ex sician burial	edi						,11/16/06	<u>rr                                   </u>			Tood Da	ate of deli			
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ivisiou or Atten after death Director:	fica	2 Accident 3 Suicide		not be 28e. Plac	e of Injury - At h	ome, farm, stre	et, factory, office bu	uilding, etc	. 2			lumber o	Rural R	oute Number, 0	City
Division  Division  Division  Parten  Hours after death  Interal Director:  Y filled in by the	Certification:	Suicide  4 Homicide	deterr							or Town,	State)				
Di Hospital 24 hours. Funeral		29a. Certifier	Certifying Ph	ysician: To the be:	st of my knowled	ge, death occu	rred at the time, da	te and plac	ce, and c	due to the cau	ise(s) and ma	anner as	started		
To the Hos within 24 h To the Fu	Medical	one) 2 🗸	Medical Exam	niner: On the basis and manner s	of examination a	and/or investiga	tion, in my opinion,	death occ	urred at	the time, date	e and place,	and due t	o the cau	ise(s)	
To To	Me	29b. Signature and	title of certifier		O O	_	29c. License	e number			29d. Date	signed	(Month, E	Day, Year)	
		( Ox	real	HAD	2 Va	in	O.C.N	M.E.			Novem	ber 2,	2006		
		30. Name and addr	ress of person v	who completed cau	se of death (Item	1 23a)									
		Carol Allan,	MD Ass	istant Medical	Examiner	111 Penn	Street, Baltimo	ore, MD	21201						
S	tate	31. Date filed (Mon			egistrar's Signati	ure d	A STATE OF	· · · · · · · · · · · · · · · · · · ·							
Regis	trar	N	0V 1 3	2006	Cospania A	J. Salah									

		1	For State Registrer	State of Ma		d / Depa		of H	ealth a				nne		35657
	ysicia	an	1. Decedent's Name (First, Middle, Last	OLLIN	S						2. Date of De. Month	Da	Ye.	ar 6	3. Time of Death
Y No. 2	Medic kamin		4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location o		ımbia	4c.	County of D	eath How	ard
	neral ector		5. Social Security Number 6. Se 216-12-8160			s <i>t birthday)</i> Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birt (Month, Da				ice (State or Foreign y) nnessee
e Maryland	lified at		Usual Residence of Decedent  10a. State 10b. County  Maryland Ho	ward	10c. City,	, Town or Lo	cation	E	Elkridge		,			10	d. fnside City Limits
h with th	st be no	al Dire	10e. Street and Number 6717 Deep Run Parkwa	ау			10f. Zip	Code	210	75		10g. Cit	izen of What	Counti J.S.A	
Nore, Maryland 21215-0036  ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If flem 27 is marked other than "natural", or Iteme 23a or 28a-f show	Exeminarriu	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1  Yes 2 ff Yes, Give Year or Dates:		1	Was Deced if Yes, spec	1	spanic Origin, Mexican Specify:	gin? (Spe , Puerto	ocify Yes or No Rican, etc.)		14. Race - A Black, W Specify:	/hite, e	
1215-00 within 72 ho ane. then "netur	ne Medical I	mpieted	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0·12)		5+)	16a, Deced (Give life, I	dent's Usua kind of wor DO NOT us	k done d e retired)	urina most		ng	16b. K	ind of Busine	wn H	•
Maryland 21215-0036 at 2 should be filed within 72 hours aff tith and Mental Hygiene. 77 is marked other then "natural; or	atic event, I	To Be Co	17. Father's Name (First, Middle, Last)	J. Allen							(First, Middle,		Sumame) ell Allen		
e, Mary 1 and 2 sho Health and I	ther traum		19a. Informant's Name/Relationship (7)  Mr. Joseph Sears, Sr 20a. Method of Disposition				84 York	towne		Daytoı	il Route Number na Beach, Pate	Florid			
Baltimore, permit. Pages 1 ar Department of Hea	any injury or o once.	· ·	1 Burial 2 Cremation 3 4 Donation 5 Other (Specify 21. Signature of Funeral Service License	) /	СӨ	metery, crer Good St	natory or of	Ceme	etery	11/	10/2006	200. C.			Maryland
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Physic Person and Assicien and Assicien and Assicien and Assicien and Assicient and As	dical inner private pr	cai Examiner	Immediate Cause (Final disease or condition resulting in death)  Security list condons if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as  b. Due to (or as  c. Due to (or as  d.	a consequ	OTE	-1076	28116	RITIS					Q.	le week
Geath certificate attending pt	detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic pro						23d. Date of Month		y Day Year
	should be deta	þ	Part II. Other significant conditions of			Iting in the ui	, -	ause give	n in Part I.		23e. Did t		^		cause of death?
T H E	page 2	Completed	OSTED ARTI	HRITIS							24a. Was autor perfo		prior	to com	sy findings available pletion of cause of
On of ding Phy After this	ē	ation: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manger of Death 1 Natural 5 Pending investigation	Hospitaf: 1 ☐ Inpati 28a. Date of Inju (Month, Da	ıry	ER/Outpatier 28b. Time of Injury		8c. fnjury Work	at Nu	rsing Ho	n (Check only on me 5 ☐ Resident Section 128d. Describe	dence		Specify)	
Division tall or Attender safter death all Director:	completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	208. Flace of In	jury - At hor tc. (Specify,		reet, factory	, office			28f. Location (: City or Tou	Street ar wn, State	nd Number of	r Rural	Route Number,
To the Hospital ( within 24 hours at	npletely fill	hedical	(Check only 2 Medical Examone)	ysician: To the best iner: On the basis of and manner st	of examinati ated.	ion and/or in	vestigation,	in my op	oinion, dea	th occurr	ed at the time,	date and	d place, and	due to	he cause(s)
To	e io	×	29b. Signature and title of certifier  M. B. VELLANK  8	loute			290	د ، د	number	9	j	Jo Ve	te signed (M	3 ,	2 00 6
5			30. Name and address of person who of N-B-VELLANKI, 8	completed cause of cold	death (ftem	23a) (Type,	Print	CNA-	7. #	308	COLU	4HBi	A, M	9	21045.
R	Sta egistr	te	NOV 1 3 2006	32. Regist	rar's Signat	ure	S. A.								

			State	State of Marylan		artment of H rtificate of			giene Rag. No.2 () (	06 35658
			1. Decedent's Name (First, Middle, Last)			timodio or		2. Date of Dea	ath	3. Time of Death
	Physicia /Medic		Frederick	Cassi	5			Novemb	er 8 20	206 11154 M
4	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, o	or Location of Death		4c. County	
			North West to 5. Social Security Number 6. Sex	7. Age (In yrs.	last hirthday)	Kanda If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Bal	9. Birthplace (State or Foreign
	Funeral Director			M 2□F 86		Months Days	Hours Min.	04/07/	1920	Country) NY
	D D		Usual Residence of Decedent	100 6	v. Town and					10d. Inside City Limits
	ehow	ž	MD BALTIMO		y, Town or Lo	IMORE				1 ☐ Yes 2 🔀 No
	28a-f	Director	10e. Street and Number	\L	DALI	10f. Zip Code			10g. Citizen of W	
	h with		600 SUDBROOK LAN	Ξ			21208			USA
	eme ?	Funeral	11. Marital Status	2. Was Decedent Ever in U Armed Forces?		Was Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)		e - American Indian, ck, White, etc.
36	be filed within 72 hours after death with the Maryland Hygiane. Hygiane Hygiane dether than "natural", or items 23s or 28s-f show event, the Madical Examinar must be motified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1 XX Yes 2 □ No WW If Yes, Give Year or Dates:	VII	1 ☐ Yes 2 🂢 No	Specify:		Specify	wHITE
215-0036	2 hour	ted t	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occup	pation		16b. Kind of Bu	usiness/Industry
215	thin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12) 12	College (1-4or 5+)	life.	DO NOT use retire	during most of world)	king	CLOTUIN	JC.
N.	filed wi Hygian ther th	Con			SALE	:5	18. Mother's Nam	o /First Middle	CLOTHIN	
and	d be fi	Be C	17. Father's Name (First, Middle, Last) RALPH		CASS	SIN		IFER	Maiden Sumam	CAPONE
Maryland	should be and Menta is marked sumatic ev	은	19a. Informant's Name/Relationship (Typ	e, Print)			and Number or Ru		or, City or Town,	State, Zip Code)
	as 1 and 2 should b of Health and Ment I Item 27 is marked r other traumatic		SUSAN CASSIN / DAI				OURT - BA			
altimore,	Pages 1		20a. Method of Disposition 1   ↑ Burial 2 □ Cremation 3 □ Re	emoval from State	cemetery, cre	osition (Name of matory or other pla		Date		City or Town, State
Ē	permit. Page Department i Important: fi any Injury o		4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service License			OM MEMOR		.0/2006		STERSTOWN, MD
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9 X	nding use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	Bc. If yes, outcome of pregn		76			23d. Dat	te of delivery
Division of Vital Records, P.O. Box	The law requires thet the death certificate has been signed by the attending lagge 2 should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Feta 4 Pregnant at time of c 9 Unknown		□Ectopic pregnand □ Other (specify) _	;y 		Mo	nth Day Year
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co	s been shou	lete						24a. Was	an 24b. V	Were autopsy findings available
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ita	ortifica octor, p	Bec	25. Was case referred to medical examiner?					ith (Check only o	nne)	
<u>ه</u>	Physician: r this certific ral director,	2	1 Yes 2 No H.	ospital: 1 / Inpatient 2 - 28a. Date of Injury	ER/Outpatie	nt 3L DOA		ome 5 Resid	dence 6 Oth	
ono	ding I th. After funer	tlon	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Wo	ork? ]Yes 2∐No	200. 00301100 1	iow anjury occurr	-
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Ö	ital or irs afte rel Dir led in									
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier  (Check only one)  Certifying Phys  Check only 2 Madical Examin	sician: To the best of my known.  In the basis of examination and manner stated.	owledge, dea ation and/or in	th occurred at the t nvestigation, in my	ime, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and ma date and place,	and due to the cause(s)
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/	0		11 11 11 11	mpleted cause of death (Ite	m 23a) (Type	, Print)	Randa	lletana	a Mar	uland
Ų	St	ate	Christine Kajub 31. Date filed (Month, Day, Year)	32. Resistrar's Sign	ature	Road P	Nanaa	100	11 10 (41	7 19 101
	Regist		NOV 1 3 20	32. Registrar's Sign	18. 1	THE STATE OF THE S				

			1_ For State	State of Maryla					0000	05750
			1. Decedent's Name (First, Middle, Last)		Cen	tificate of	Death	Reg.	N2006	35659 3. Time of Death
	Physici /Media		LISA			DEG	RACE		Day Year 700	
	Examin		4a. Facility Name (If not institution, give s	11 - 11 -	-//	4b. City, Town, o	r Location of Dea	uth	4c. County of Del	ath
	Funeral		5. Social Security Number 6. Sex		( last birthday)	If Under 1 Year	MULE If Under 24 Hr		9. Bi	rthplace (State or Foreign
	Director		011-70-1100	M 2XF 3	7 Yrs.	Months Days	Hours Mir	. (Month, Day, Ye	ear) (	COUNTRY LAND
	/land		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Loc	ation				10d. Inside City Limits
	e Man	ctor	MD		BALTI	MORE	Ci	TY		1 Yes 2 □ No
	with th	Director	10e. Street and Number		APT 6	10f. Zip Code	201		Citizen of What C	_
	death me 23	Funerai		Sarataga 12. Was Decedent Ever in 1	J.S. 13, W		•		14. Race - Am	STATES
ထ္ထ	or ite		1 Never Married 2 Married	Amed Forces? 1 ☐ Yes 2 No If Yes, Give		Yes, specify Cuba ☐ Yes 2 No	an, Mexican, Puè Specify:	Specify Yes or No- rto Rican, etc.)	Black, Whi	
2-0036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or iteme 23a or 28a-f show ent, the Medical Exacilinat must be rectified at	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educ	Year or Dates:		ent's Usual Occup		1.00	Specify:	SIACK
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2	led will tygien her tha		1044		Hoi	NEMA				Home
Maryland	d la b	o Be	17. Father's Name (First, Middle, Last)  TYZONE	DEG:	PACE		18. Mother's Na	ime (First, Middle, Maid	den Sumame) EG2AC	
ary		스	19a. Informant's Name/Relationship (Typ			Address (Street			•	Zip Code) 2/201
	s 1 and 2 f Health a fem 27 is other trai		Sandra Dorsey	/ MOTHER	823	W. Sa.	ratoga	ST. APT	6 BALTI	More, Md Town, State
Š			20a. Method of Disposition  1 Burial 2 □ Cremation 3 □ Re							
altimore,	교본문증.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License		T. CAR.	NE C	ss of Facility /2	1-11-2006 sadon = 6	DUNG river Fi	uneral Home P. D
m —	Deperminant Important		Marker &	30 MO145	52 28	18 E. BI	ALTIMOS	c 57. BAG	TIMORE	md 21204
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	eations that caused the dea e cause on each line.	th. Do not enter	the mode of dyin	g, such as cardia	c or respiratory arrest,		Approximate Interval Between
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٥	certifica nding ph use as th	Medi	IF FEMALE:							
X Q Q	of the att	ician/Me	in the past 12 months?	c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	al death 3 □E	ctopic pregnancy other (specify)			23d. Date of de Month	livery Day Year
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	w requires that the been signed by the should be detached.	by P	Part II. Other significant conditions conti	ributing to death but not res	sulting in the und	erlying cause give	en in Part I.			the cause of death?
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	has has	ошо						24a. Was an autopsy performed?	24b. Were au prior to death?	utopsy findings available completion of cause of
	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?				26. Place of Dea	1 ☐ Yes 2 ☐ ☐ ath Check only one	√6 1 □ Yes	2 No
5	G № X	P.	1 ☐ Yes 2 ☐ № Ho 27. Manner of Death		ER/Outpatient		4 Li Nursing r	lome 5 ☐ Residence		cify)
	a fe	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c, Injury Work	rat :? ∕es 2 ∐No	28d. Describe how in	jury occurred	
UNISION	r Attendi er death. rector: A by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At his building, etc. (Specif	ome, farm, stree			28f. Location (Street	and Number or Ru	ural Route Number,
2	pital o urs aft srai Di illed ir		20.0.45					City or Town, Sta		
	To the Hospital or Attending Ph within 24 hours attendeath. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	cian: To the best of my knows: On the basis of examina and manner stated.	owledge, death o tion and/or inves	ccurred at the tim stigation, in my op	e, date and place sinion, death occu	, and due to the cause irred at the time, date a	s) and manner as nd place, and due	stated. to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier			29c. License		I	Date signed (Monti	
			Fally MO	_		RES-	000	No	VEMBER	6,2006
•			30. Name and address of person who com		n 23a) (Type, Pri	DIFE A	L Roll	No inver, Mi	aculan1	2000
	Stat		31. Date filed (Month, Day, Year)	32. <b>Fi</b> egistrar's Signa	iture	chi s	LAT I	111000 111	MIGHT	0.73
	Registra	II.	NOV 1 9 2006	) Parish &	A DE PROPERTY	-KASSEL.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 35660 State Registra Amend #5 Per FH 0862 12/29/06 JH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** November Robert Edward Donohue, Sr. 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner imore Kosedak Franklin 59/ ware Hospita If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 21, 1929 5. Social Securit (1927) oe 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □XM 2 □ F 189-22-0232 Director Pennsylvania Usual Residence of Decedent the Maryland 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits or 28a-f show is marked other than "naturel", or iteme 23s or 28s-1 ehov raumatic event, the Modical Examiner must be multified at 1 Yes 2000 Directo Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 3902 Briar Point Road 21220 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. XXYes 2 No If Yes, Give Year or Dates: 1951-1 Never Married 2 Married Dono Huc Baltimore, Maryland 21215-0036 1 Yes XX No Specify: Specify: φ 3 ☐ Widowed 4 ☐ Divorced 1953 White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Department Chief Telephone Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental Lawrence Donohue, Sr. Julia Agnes McMahon ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 is Depertment of Health ar Importent: If item 27 is any injury or other trauonce. (Wife) 3902 Briar Point Road, Baltimore, Maryland 21220 Margaret Donohue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus 11/13/2006 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Sacilinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearf failure. List only one cause on each line. Approximate tmmediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** una rer an /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine or Attending Physicien: The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physicien by Physician/Medical the as anding use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery atten for u 3 ☐ Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? -mholi Yes been si should Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an certificate has t irector, page 2 s autopsy 2VZ No 1 Yes director Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manufer of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funerel Direct completely filled in by 4 Homicide o the Hospitel Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 November 9, 2006 1 MD 1011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Henry Sun, MD Square Franklin Dink Biltimore, Manyland

State

Registrar

31. Date filed (Month, Day, Year)

NOV 1

32. Registrar's Signature

2005 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Dorsey James 11 07 2006 3:45p/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MD 1003 Homewood Avenue Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Months Min. Hours 215-40-6006 Director 05–12–1941 Md. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

nnt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits must be notified at Y Yes 2 □ No **Funeral Director** Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1003 Homewood Avenue 21202 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. other traumatic event, the Medical Examiner 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Completed by Specify: 3 ☐ Widowed 4 € Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Parksabd Rec. llth grade Bus\_Driver City of Baltimore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Η. Dorsey ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5216 Kramme Ave., Apt. 1, Brooklyn, Md. Jennifer Dorsey Daughter Department of Healt Important: If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11-13-06 King Mem. Park Randallstown, Md. Donation 5 ☐ Other (Specify) Signati e of Funeral Service Licenses 22. Name and Address of Facility March F.H. East 1101 E. North Avenue, Baltimore, Md. 21202 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** disease or condition resulting in death) as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records. Completed by 1 ves 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 2 110 To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director. D 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 □ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ۵ 6 ☐Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signa 29d. Date signed (Month, Day, Year) 00056934

State Registrar EAST EAGKE ST

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MP

2006

1000

32. Registrar's Signature

DIANA HISFFNER

31. Date filed (Month, Day, Year)

GENE E. GREEN, UD.

BATTURELL,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien® 11 5 35662

		1 - For State Registrar	State of Maryla		rtificate o			eg. No.	O	33002
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Physic /Medi		Aline Esther Davis	S					ber 09, 2		0145 M
Exami	ner	4a. Facility Name (If not institution, give s	treet and number)	AL	4b. City, Town	or Location of Death	RE	4c. County of	of Death	
Funeral	11 1100	5. Social Security Number 6. Sex		rs. last birthday,	ff Under 1 Yea	r If Under 24 Hrs.	8. Date of Birth (Month, Day,	Vasal	9. Birthpla	ace (State or Foreign
Director		264 <b>-</b> 12-0189	<sup>M 2</sup> √2 F 91	Yrs.	Months Day	s Hours Min.	9/13/19		Couint Maypo	rt, FL
D .		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or L	ocation				10	d. Inside City Limits
Aaryla F sho	ō	MD Baltin		atonsvi						XIXYes 2 □ No
the h	Director	10e. Street and Number		a come v i	10f. Zip Code	)	1	0g. Citizen of W	hat Count	ry?
h with		707 Maiden Choice	Lane, Apt.	8-G-13	21228	3		USA		
eme	Funeral		2. Was Decedent Ever in Armed Forces?			f Hispanic Origin? (Spuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)		- America , White, e	
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73-0000 172 hours after death with the Marylar "natural", or Iteme 23e or 28e-1 show salical Examiner must be multiled as		15. Decedent's Educ	ation	16a. Dece	dent's Usual Occ	upation		16b. Kind of Bus	iness/Ind	ustry
within 72 ene. then 'na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work dor DO NOT use reti	ne during most of work red)	king			
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ie, Mal ylaila Kit. s i end 2 should be filed within if Haith and Mental hygiene. Item 27 is marked other then other traumatic event, the	5	Samuel Thomas Si  19a. Informant's Name/Relationship (Type		19b. Mail	ina Address (Stre	et and Number or Rui	Mae Greei rai Route Number		State, Zip (	Code)
	1	Suzanne Mrozinski/				Dr., Elkr				
Dattilliore, IN Department of Health Important: If Item 27 any Injury or other tr once.		20a. Method of Disposition	20	b. Place of Disponentery, cre	osition (Name of matory or other p	lace)	Date	20c. Location - 0	City or Tov	vn, State
Page Page nent c	1	X⊠ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		Memorial		11/06	Elkrid	l je	
Dattillors permit. Pages 1 Department of H Important: If Ite any Injury or ot once.		21. Signature of Funeral Service License		199	2. Name and Add	I come to comp	Hame @ MV	P. Inc.		
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	Н	shock, or heart fillure. List only on Immediate Cause (Final	e cause on each line.	1 I	EFFU.	(1 A N	or respiratory arre	531,		Interval Between Onset and Death
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the death ce by the attendia	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time		Other (specify)			Mon	th [	Day Year
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tSIC ttend death ctor; /	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of fnjury - A	At home, farm, st			28f. Location (St	reet and Numbe	r or Rural	Route Number,
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To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Phys	sician: To the best of my ter: On the basis of exam	knowledge, dea	th occurred at the	time, date and place,	and due to the carred at the time.	ause(s) and mar	ner as sta	ited.
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97		20 November 1	molecule course of death (	Itam 22a) /T	Print)	1210	100	VOTOTA	2 11	7
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Registrar

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	Physici /Medic		Agnes R. Dobrzycki		November	r <sup>Day</sup> , 2006	11:45 A <sup>M</sup>
4	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	h
4	<u> </u>	À	3006 Rosekemp Avenue  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday,	Baltimore If Under 1 Year If Under 24 Hrs.	8. Date of Birth	N/A	hplace (State or Foreign
*	Funeral Director		217-09-9352 1 M 2 F 98 Yrs.	Months Days Hours Min.	(Month, Day, Y	rear) Coi	yland
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	the M	ecto	Maryland N/A Baltimor	10f. Zip Code	100	g. Citizen of What Co	
	3a or	ă	3006 Rosekemp Avenue	21214		United Sta	
	death me 2:	Funeral Director		Was Decedent of Hispanic Origin? (Spe	cify Yes or No-	14. Race - Amer	ncan Indian,
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Iteme 23e or 28e-f show says injury or other traumatic event, the Marklaal Examinant intellible mulliad at once.	y Fu	1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto F  1 Yes 2 No Specify:	nican, etc.)	Specify: White	ite
Maryland 21215-0036	urel',	d by	3 Year or Dates:			*****	
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eg —	Depar Impo		Jain J. Miller 4	2. Name and Address of Facility Davi	et Baltin	more, Mary	land 21231
			23a. Part1. Enter the disease or complications that caused the death. Do not en shock, or heart failure. List only one cause of each line. Immediate Cause (Final	ter the mode of dying, such as cardiac of	r respiratory arres	t,	Approximate Interval Between Onset and Death
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Division of	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined building, etc. (Specify)	reet, factory, office 2	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
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	To the Hospital or Attending Physician: The law within 24 hours effer death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Med	one) and manner stated.  29b. Signature and tithe of cestifier.	29c. License number	290	d. Date signed (Month	ı, Day, Year)
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	10		30. Name and address of person who completed cause of death (Item 23a) (Type	Print) 8903 (	LAR	TODS	2006
/	V		31. Date filed (Month, Day, Year)  32. Redistrar's Signature	BACT	600	210.3	1000
	Sta Registi		NOV 1 3 2006	Joseph	y 91	( - / 5	

Juanita Marie Maz 06-08480

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**UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle, Last) Date of Death Physician/ Month Day November 7, 2006 Juanita Μ. Diaz 2147 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** University Hospital n/a 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 9 Birthplace (State or **Funeral** Day Hours Director unk Country Maryland M 2 XF 42 Sept.14 1964 Usual Residence of Decedent IOc. City, Town or Location 10d Inside City Limits any or items 23a or 28a-f show must be notified at once. Md. n/a 1XX Yes 2 No Baltimore nours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21230 U.S.A. 2319 Washington Blvd. Funeral 13 Was Decedent of Hispanic Origin? 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Informant's Name/Relationship (Type, Print) Rebecca Roberts (Sister) 603 Monterey Court, Joppa, Md. 21085 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory 11/10/2006 Baltimore, Md. 4 Donation 5 Other Specify 21, Signature of Funeral Service Ligs 22. Name and Address of Facility. McCully-Polyniak Funeral Home P.A. Patapsco Street dying, such as cardiac or respiratory Baltimore rrest, shock, or heart 28a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of **Physician** Between Onset and failure List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate ne cause. 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Was case referred to medical To the Hospital or Attending Physician: Division of Vital Other<sub>4</sub> Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 DOA Nursing Home 5 1 🗸 Yes 28a Date of Injury (Month, Day Year) Nov 7, 2006 27. Manner of Death 28b Time of Injury 28c. Injury at Work 28d. Describe how injury occurred Certification: Pedestrian struck by motor vehicle 2046 hrs Natural 5 Pending 1 Yes 2 V No Director: the 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) 2000 Washington Boulevard, Baltimore, Md. 24 hours a (Specify) Major Road / Highway Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical To the F 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29d Date signed (Month, Day, Year) O.C.M.E. November 8, 2006 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) NOV 1 3 2006 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ 0 0 6 35665 1 - For Inf, G864, 2/7/07 TT Registrar Certificate of Death Reg. No. 2. Date of Death **Physician** /Medical 4c. County of Death 4b. City, Town or Location of Death Examiner If Under 24 Hrs. **Funeral** Months Days Hours 1□M 2 Director e filed within 72 hours after death with the Maryland at Hygiene.
other than "natural", or Itame 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itame 23a or 28a-f sho other traumatic avent, the Mydical Examinar must be notified at 1 Yes **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 00/04 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status 1 Never Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No Specify: Completed by 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation condary (0-12) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any injury or other traumatic event. Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Sign July of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DEMENTIA STAGE **Physician** END Month /Medical Due to (or as a consequence of) Examiner THRIVE FAILJRE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine cete has been signed by the attending physician end page 2 should be detached for use as the burial-transit ATRIAL FIBRILLATION MONTHS Due to (or as a consequence ol) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 Whknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificete has 1 Yes 2 No 1 ☐ Yes To the Hospitel or Attending Physician; within 24 hours after death.
To the Funeral Director; After this certifice completely filled in by the funeral director, to 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide 29a. Certifier La Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Spoke MD DO0 5 3150 NOV 11 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE 110 SANTIAGO RD

State Registrar

DHMH 17 Rev 1/2001

NOV 1 3 2006

SHALLUNMAL

31. Date filed (Month, Day, Year)

9650 GUPTA Registrar's Signature

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		•	For State Registrar		State o	f Marylar	nd / Depa <i>Ce</i>	artmen <i>rtificat</i>	t of H e of L	lealth a D <i>eath</i>	and M	ental Hy	/giene Reg. No		6	35	666
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	/Medic Examir Funeral Director	ier	4a. Facility Name (I	f not institution, g	ive street and nur	7. Age (Ih yrs.		4b. City, R If Under Months	056	Location of If Under Hours	24 Hrs.	8. Date of Bi (Month, D Aug 26	irth	County of E	Birthpla Countr	O State	<u> </u>
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	r 28a-f et	Director	MD 10e. Street and Nur	Baltin mber	nore		Dunda	1k 10f. Zip	Code				10g. Cit	izen of Wha	t Countr		2 No
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036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland scriment of Health and Mental Hyglene. Ortant: If Item 27 le marked other then "natural", or Items 23a or 28a-f ehow injury or other traumatic event, the Madical Exerciting must be notified at as	by Funeral	11. Marital Status	ied 2∭ Married	12. Was Dece Armed Fo	2 X No ′e		Was Deced If Yes, spec	lent of Hi of Cuba			cify Yes or Nitican, etc.)	0-	14. Race - / 8lack, V Specify:	America Vhite, et	tc.	
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Division of Vital Records,	c ta :: e	Certification;	2 Accident 3 Suicide 4 Homicide	investigate 6 Could not determine	be 28e. Place	of Injury - At ho	ome, farm, str	М	1 🗆 Y	/es 2 □ N		3f. Location ( City or To	Street and wn, State	d Number o	Rural F	Route Nun	ber,
	To the Hospital or Atter within 24 hours after de To the Funeral Directo completely filled in by th	ledical C	29a. Certifier (Check only one)	1 Certifying F	Physician: To the aminer: On the ba	isis of examina	wledge, death	occurred a	at the tim in my op	e, date and inion, deat	d place, ar th occurred	nd due to the d at the time,	cause(s) date and	and manner place, and	r as stat due to th	ed, ne cause(s	s)
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	Registr	ar	N	nv 1 3 2	006   🌆	ALLEN S	J. SAA	A CONTRACTOR OF THE PARTY OF TH									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 2861 11-13-06 vt. State of Marytand Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Di Alessandro 2. Date of Death Antonio **Physician** October a/k/a Anthony /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOPKINS Johns Baltimore If Under 1 Year I If Under 24 Hrs. int 11000 7. Age (In yrs. 38 5. Social Security Number last birthday **Funeral** 9. Birthplace (State or Foreign Days 1**X**M 2□F Hours Months 01/21/1968 Wilmington, DE Director 222 Yrs 62 7079 Usual Residence of Decedent the Maryland 10a State 10b Count 10c. City, Town or Location 28a-f ehow 10d. Inside City Limits Item 27 le marked other then "naturel", or Iteme 23a or 28a-f ehov other traumatic event, the Modical Examinar must be notified at Director 1 ☐ Yes 2 No DE New Castle Middletown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 106 North Ingram Court 19709 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1) fes 2 No If fes, Give Year or Dates: Specify: White 1 Yes 2X No Specify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 4 State Police Trooper Law Enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be le marked o 9 Marcello DiAlessandro Barbara Marie Sheridan pinous 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Item 27 Angela C. DiAlessandro 106 North Ingram Court, Middletown, DE 19709 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Slate Department of Important: If It any Injury or o ŏ X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cathedral Cemetery 11/02/2006 Wilmington, Delaware 22. Name and Address of Facility

Krienen-Griffith Funeral Home
1400 Kirkwood Highway, Wilm., DE 19805 21. Signature of Funeral Services icensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Bilateral Lung Transplant 8 hours /Medical Due to (or as a consequence of): Examiner Pulmanacy F, 1 Due to (or as a consequence of): years Fibrosis Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Sclerodermo Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Hodakins Lymphoma 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate Allograft Dysfunction Chronie 1 Yes 2 No 1 Yes 2 No director. Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No ဥ 2 ER/Outpatient 3 DOA After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury al Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury deeth. 1 Yes 2 No efter deeth 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide within 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier cal 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) 1 3 2006

FITTON

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TORIN

600 NORTH 32. Registrar's Signature

, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WOLFE STREET, BALTIMORE, MARYLAND 21287

RES-000

October 28, 2006

Maryland 21215-0036

Saltimore,

certificate be executed

requires that

Attending Physician:

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Box 68760.

P.O.

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	xamir	ier	4a. Facility Name (If not institution, give 1027 N. BROADW)	ΑY		BALT	LOCATION OF DEATH		4c. County of De	
	neral ector		5. Social Security Number 6. Sec. 212 60 3497 Usual Residence of Decedent	X	lge (In yrs. last birthday)	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day APR . 1		irthplace (State or Foreign Country) MD
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21215-0036 Id within 72 hours after death with the Maryland gjene.	i naturei, or tems 23a or 28a-l'enow ledical Examinat musi be notified at	i by Funerai	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 Tyes 2 If Yes, Give 2 Year or Dates	S? No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: BI	ite, etc.
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Baltimore, permit. Pages 1 ar Department of Hea	= 5		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I		9 🦾 .	matory or other plac	ce)	Date	20c. Location - City of	
Baltim permit. Pag Department	injury P.		4 □Donation 5 □ Other (Specify, 21. • nature of Funeral Service Licens		MT.ZION	CEM.  2. Name and Addres		17,200	6 BALTO,	MD.
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Division of Vital Records, el or Attending Physician: The law requires to a stere death.	d in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	ijury - At home, farm, stri tc. (Specify)	eet, factory, office		28f. Location (St City or Town	reet and Number or Ri n, State)	ural Route Number,
Division To the Hospitel or Attending within 24 hours after death	completely filled in by the funer	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the besiner: On the basis and manner s	t of my knowledge, death of examination and/or inv tated.	occurred at the tim vestigation, in my op	e, date and place, a inion, death occurre	and due to the ca	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
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			1 affres CA	~ M.S	,	D00	62073		ovenhor 1	0 , 2006
1			30. Name and address of person who co			Print)	0 11.		00000000	0,2006
			Jeffrey R. Intente 31. Date filed (Month, Day, Year)		101 North B.	oudway	Baltin	ore, Mi	21212	
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# Please Type or Print in Black Indelible Ink

Michelle Denise		shield 1- For State	State	of Maryla	and / De		nt of He	alth ar			giene			
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Medical Exami	400/	Michelle Denise	Dashi	.eld							Month November	7, 2006 Year		0945 hrs
		4a. Facility Name (if not instite Harbor Hospital Ce		street and nu	mber)			y. Town, o Itimore	r Location of	Death		4c. County o	f Death	
Funeral		5. Social Security Number	6. Se		7. Age (In y	yrs. last birthday)  If Under 1 Year  If Under 24H  Months Days Hours M			24Hrs.	Foreign				
Director		216-84-1906		M 2 X F		38 Yrs. Months Days Hours Min.			14011.	07/28/1968 Country) MD				
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Aaryla 28a-f	Director	10e. Street and Number			·		10f.	10f. Zip Code			10g Citizen of What Cour			try?
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		2826 Winwood Cou	ırt	<del>-</del>		21225					USA			
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/Medical	1	failure. List only one cause on each line  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):												Between Onset and Death
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7	Je.	Sequentially list conditions, if any, leading to immediate	Ī	Due to (or as a	consequen	ce of):								
F	Examiner	(Disease or injury that initiate events resulting in death) La	d C.	Due to (or as a	consequen	ce of):							-	
<b>0,</b> be executed sician and ourial - transit			d										[	
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6876C certificate nding phys	ian/Me	IF FEMALE: 23b. Was decedent pregnant i past 12 months?	n the	23c. If yes, of	outcome of p	pregnancy 2	Fetal dea		Ectopic p		су	23d Date of o	delivery Da	ay Year
	sicia	1 Yes 2 No 9	Jnknown	1	ant at time o	f death 5	Other (S	pecify)						
). Be the de by the	Phy	Part II. Other significant con		Ja Olikilo		ot resulting in	n the underly	ing cause	given in Part	t I.	23e. Did to	pacco use contrib	ute to th	e cause of death?
P.O. es that the igned by be detach	φ	Liver Cirrho					,				1 Yes	2 No 3	Proba	bly 4 🗸 Unknown
rds, requir	Completed										24a Was a			psy findings available mpletion of cause of
eco he law ite has	Ę.										perform	med? de	eath?	
al R	Be C	25. Was case referred to med		_				26.Place	e of Death (C	Check or	U* 1		<b>V</b> 100	
of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by Tuneral director, page 2 should be detach.	일	examiner?  1 ✓ Yes 2 No			·	<b>✓</b> ER/Outp		DOA				Residence 6	Other:	
n of viding Ph.	- 1	27. Manner of Death  1 X Natural 5 P	ending	28a. Date (Month,	of Injury Day,Year)	28b. Tin	ne of Injury	1	ıry at Work? Yes 2 ☐ N		28d. Describe h	ow injury occurred	d	
ivision I or Attend after death. Director:	icati	2 Accident In	vestigatio	28e Place	e of Injury - /	At home, farm	n. street, fact				28f. Location (S	treet and Number	or Rura	Route Number, City
O Loring to the state of the st							• '			or Town, St			,	
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To th within To th	Medi	29b Signature and title of cer		and manner st		on and/or inve		29c Licens		urred at	trie time, date a			
		Ques?	le of certifier 29c. License number 29d. Date signed (Mc O.C.M.E. November 8, 20											
		30. Name and address of pers	on who c	ompleted caus	e of death (	Item 23a)								
				nt Medical E	xaminer	111 Pe	nn Street	, Baltim	ore, MD 2	21201				
St Regist	~~	31. Date filed (Month, Day, Ye NOV	ar) 3 2	32. Re	givtrar's Sig	nature	have	K)						
Regist	T.T.	1107	- J 6		-		7	-						

State of Maryland / Department of Health and Mental Hygiene, 35670 Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 11 **Physician Epps** 2006 Thelma 11:30 A·M /Medical 4c. County of Death
Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Towson 409 Virginia Avenue 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 😿 F Yrs. 219-01-2224 86 Md. Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a. State 10b. County 10c. City. Town or Location r 28e-f ehow Y☐Yes 2☐No Director Baltimore Towson 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code rai', or iteme 23a or Examiner wast be 409 Virginia Avenue 21286 USA filed within 72 hours after deeth Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black δ netural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Custodian Various other t 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy importent; if Item 27 Is marked oth eny linjury or other treumatic event ADEs. Robert Florace Pearl Montford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Murrill Epps Son 1368 Pentwood Road, Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Greenmount Cem. 11-11-06 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 21202 1101 E. North Avenue, Baltimore, Md. M) cure 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) C.O.P.D 5 YEAR Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day 5 Other (specify) 4☐Pregnant at time of death Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Amylowosis autopsy performed? 1 Yes 2. No ours after death.

neral Director: After this certific
filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier 29c. License number J07132 d cause of death (Item 23a) (Type Print) Fairmount Ave. St. #330 TOWSON, Mol. 21286 515 31. Date filed (Month, Day, Year) Registrar's Signature State 3 2006 NOV 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Z U U h 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Mildred Ruth Eid 2006 2:15p November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll Manchester Long View Nursing Center If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Year. Months Days Hours 1 ☐ M 2 🖫 F 219-12-5242 Sept 27 MD 1922 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Carroll Manchester Md1 ☐ Yes 2 X No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examinar mind once. USA 21102 3329 Kensington Square Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🙀 No Specify: Specify: white ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) teacher of radiology denta1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Phillip Rich Mary Peeples ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3329 Kensington Square, Manchester, MD 21102 Mr. Louis John Eid (spouse) Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11-11-06 Finksburg, MD 4□Donation 5 Nother (Specify)entombment | Evergreen Mausoleum 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Page Hought Sterbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner sequentially liet our differentially leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 autopsy perform certificate 2 No 1□ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 🗌 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA After this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division or Vital Records,

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

NOV

of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

State of Maryland / Department of Health and Mental Hygiene Reg. No. UUD Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Fakhrian-Shemirani Khadijeh November 8, 2006 9:35 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8801 Lowell Street Montgomery Bethesda If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Year) Months 1 □ M 2 🖸 F 91 March 19, 1915 Iran 219-72-2008 Director Usual Residence of Decedent Maryland 10b. County 10c. City, Town or Location 28a-f show rai", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be n 20817 8801 Lowell Street United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 þ Specify: 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Service Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be not available not available 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8801 Lowell Street, Bethesda, Maryland 20817 M. Grace Michaud / Friend 20b. Place of Disposition (Name of cemetery, crematory or other place)
National Memorial
Park 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State November 11 Falls Church, Virginia 4 Donation 5 Dother (Specify) 2006 21. Signature of Fury ral Service Licensee 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Cardio Respiratory Arrest resulting in death) /Medical Due to (or as a consequence of) **Examiner** Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Coronary Artery Disease and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Arrythmia Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🎇 No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Cervical Myelopathy 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 X Natural Injury 5 Pending To the Hospins, within 24 hours after death.

To the Funeral Director; A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier t ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) of certifier 29b. Signature and November 8, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10810 Connecticut Avenue, Kensington, Maryland 20895 Shamina Abbas, M.D. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 13 2006 Registrar

			For State Registrar	State of	Marylar		artment of H	lealth and M Death		giens	C U U 5	356	73
			1. Decedent's Name (First, Middle, Las	t)					2. Date of De Month	Da	v Year	3. Time of	Death
	Physicia /Medic		W	illiam	F. F	ahey			Novemb	er 8	2006	1:20	A <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give				4b. City, Town, or Location of Death  Rockville  Montgo						
			Montgomery Hospic  5. Social Security Number 6. Se		House 7. Age (In yrs.	last hirthday)	If Under 1 Year	IIILE If Under 24 Hrs.	8. Date of Bir	th	Montgome 9. Bird	nplace (State o	or Foreign
П	Funeral Director			M 2□F	85	Yrs.	Months Days	Hours Min.	1 (Month, Da	iv. Year.	1921 Wash	untrv)	
	D		Usual Residence of Decedent									10d. Inside C	
	anylan ehow	_	10a. State 10b. County		10c. Ci	ty, Town or Lo						1 🗆 Yes	1
	Ba-f	ecto	Maryland Montgome	ery		Bethe	Sd a.			10a Ci	tizen of What Co		A
	with t	급	6530 Democracy B	1111			2081	7		_	ted Stat		
	Jeeth Trees	era	11. Marital Status	12. Was Dece	dent Ever in U	J.S. 13.		lispanic Origin? (Sp an, Mexican, Puerto	ecity Yes or No		14. Race - Ame	rican Indian,	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental tyglene. Department of Health and Mental tyglene. Importent: if Item 27 is marked other then "naturel", or Items 23a or 28a-f show eny injury or other traumatic event, I'm Madical Exacili at must be notified at appea.	Be Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 📆 Widowed 4 ☐ Divorced	Armed For 1 X Yes If Yes, Give Year or Da	2□No WW	TT	it Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	Hican, etc.)		Black, White	White	
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2	Hygie Hygie ther t	ဝိ	17. Father's Name (First, Middle, Last)			1 641111		18. Mother's Nam	e (First, Middle	1		OILVEIS	LLy
and	d be i	То Ве	John Fahey					Geor	gia Kir	tle	V		
کّ	shoul nd Me mark	Ě	19a. Informant's Name/Relationship (7	ype, Print)		19b. Maili	ng Address (Street	and Number or Rui	<u> </u>			(ip Code)	
Ž	alth a		Victoria Chipa/F	riend		4400	East West	Highway, #	126, Bet	heso	la, Mary	1and 20	814
Baltimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from S	State	cemetery, cre	sition (Name of matory or other plac	Novem	ber 9,		ocation - City or		
Ĕ	Pag tment tent: I		4 ☐ Donation 5 ☐ Other (Specify	)	Mon		Crematorium	n, Inc 200		Betl	hesda, M	aryland	1
Na Na Na	Separit Mport		21. Signature of Funeral Service Licen	500	W0120	Ro	Name and Addre	mohrev Fune	ral Home/	Beth	esda-Chev	y Chase,	Inc.
	45200		23a. Part1. Eyer the disease, or comp	olications that ca	MO130			in Avenue			viand 208.	Approximat	Θ
			shock, or heart failure. List only immediate Cause (Final	one cause on ea	ach line.		•					Onset and	ween Death
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	Examiner		One of the same distance				ve Pulmo	nary Dise	ase				
	p ii	Iner	Sequentially list conditions. if any, leading to immediate cause. Enter Underlying	Due to (	of as a consec	quence of).							
	and trans	каш	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (	or as a conse	nuence of):							
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687	ificate g phys as the			, d.									
Вох	The law requires that the death certificate be executed ate has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregnirth 2 Fet		Ectopic pregnancy	,			23d. Date of deli	•	· · · · ·
B	deat he ett	sicle	in the past 12 months?		ant at time of		Other (specify)	<u>'</u>			Month	Day	Year
P.O.	The law requires thet the de sete hes been signed by the e page 2 should be detached	Phy	9 Unknown  Part II. Other significant conditions of	ontributing to de	ath but not re	sulting in the u	nderlying cause giv	ren in Part I	23e. Did 1	tobacco	use contribute to	the cause of	teath?
ds,	signe d be c	d by	Partil. Other significant conditions	orkinouting to do		55g 11,5 c	, raony and oacoo giv			Yes 2		obably 4 🔀	
Vital Records,	requ been shoul	Completed							24a. Was	an	24b Were au	topsy findings	available
Rec	he law	dm							auto	psy orm <u>e</u> d?	prior to death?	completion of a	ause of
ā		ပိ	25. Was case referred to medical					26. Place of Deal	1 ☐ Yes	2IQ No	o 1 ☐ Yes	2 No	
	Physicien: this certifice ral director, p	To B	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 🗆 II	npatient 2	] ER/Outpatie	nt 3 DOA Oth	er			6 X Other (Spec	ofy) Hosp	ice
0	ng Ph ter th neral		27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of	of Injury h, Day Year)	28b. Time o	f 28c. Injur Wor	ry at	28d. Describe	how inju	ry occurred		
Siol	Attending r death. ector: After by the fune	catle	2 Accident investigation 3 Suicide 6 Could not be					Yes 2 □ No					
Division of		Certification:	4 Homicide determined	280. Flace	of Injury - At h ng, etc. <i>(Spec</i>	nome, farm, st ify)	reet, factory, office		City or To		nd Number or Ru 'e)	Irai Houte Num	1D0r,
	Mospital or 24 hours afte Funerel Dir etely filled in	edical			sis of examin			me, date and place, opinion, death occur					5)
	To the within 2 To the complex	Me	29b. Signature and title of certifier				29c. Licens			29d. Da	ate signed (Monti	h, Day, Year)	
,	, 1		Cynthiam	mill	com	200	HOO	58032		Nov	ember 8,	2006	
3	1		30. Name and address of person who							1	M - 1	1 20055	
0			Cynthia M. Willia 31. Date filed (Month, Day, Year)		egistrar's Sign		aster Mil	ll Road,	KOCKVIL	те,	maryland	1 20855	
	Sta Registi		NOV 1 3 2	- 20	John J Gigit	Roman	P Receipt						
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#### Please Type or Print in Black Indelible Ink

Katherine Louise		lerton 1- For State	State	of Maryla		rtment of		and Ment	al Hygiene		200	6 356	7
Physicia		Re <mark>gistrar</mark> 1. Decedent's Name (Fir	st, Middle,Last)	)			Death		2 Date of De	Reg. No eath	200	3. Time of Death	
Medical Examin	er	Katherine	Louise	Fulle			4b City Town	n, or Location o		25, 2006	Year ounty of Death	1525 hrs	
		4a. Facility Name (if not 610 Fifth Street	institution, give	Street and hu	mber)		Laurel	i, or Eocation o	o Death	L L	nce George		
Funeral		5. Social Security Number	erunk <sup>6. Sex</sup>	×	7. Age (In yrs. la		If Under 1	Year If Unde	Min		CC	rthplace (State or Fo	ik <sup>gn</sup>
Director			1	M 2[X]F	5(	) Yrs		Dayo	June	27, 19	156		
ý,		Usual Residence of Dec 10a. State 10b.	edent Countv		10c City	Town or Locat	ion					10d Inside City Lin	nits
ow any			Prince	Caorga		aurel						1 Yes 2 X	No
Maryland 28a-f show d at once,	홠	10e Street and Number	TIMEC	deorge	3 1	10101	10f. Zip Co	de		10g Citizen	n of What Cou		
vith the Maryland s 23a or 28a-f shov e notified at once.	Director	610 Fifth	Street					2070	)7		USA		
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	uneral	11. Marital Status	unk	12. Was Dec	edent Ever in U.				in? (Specify Yes or I Puerto Rican, etc.)	No- 14.	Race - Amer	ican Indian, Black,	
er death wi	╙┃	Never Married  Widowed 4	2 Married Divorced	1 Yes If Yes, Give Yea	2 X No			No specify	,	Sn	pecify: wh	ite	
irs aft tural"	ğ	15 Decedent's Educat		or Dates:		16a Deceder	nt's Usual Occ	supation (Give I	kind of work done un		44 11		nk
72 hou	eted	Elementary/Secondar	y (0-12)	College (1	-4 or 5+)	during m	ost of working	g life. DO NOT	use retired)			<u>.</u>	
5-0036 lled within 7 Hygiene. I other than	Comple	unk		nk						_]			
15-0 filed v I Hygi ed othe	ပ္စို	17. Father's Name (First	, Middle, Last)				unk	18.Mother	s Name (First, Middle	e, Maiden Su	rname)	un	ıK
2121: ould be fill Mental I marked	ě	19a Informant's Name/F	Relationship (Ty	ype, Print )		19b. Mailin	g Address (	Street and Num	ber or Rural Route N	umber, City	or Town, State	e, Zip Code)	_
MD on the state of	-	O.C.M.E.				11	1 Penn	Street	Baltimor	e, MD	21201		
	ı	20a. Method of Dispositi	on remation 3	Removal fro		Place of Dispos crematory or ot		of cemetery,	Date	20c. Loc	cation - City or	Town, State	
altimore, rmit. Pages I ar ppartment of He pportant: If ite		4 Donation 5 X	Other Specify:	in sta	ate								
Balti permit. Departu Import		21. Signature of Funeral RON	Service Licens	Wade, I	Director				oard 655 V	W. Bal	timore	Street	
		23a Part Enter the dis	ease or compl	lications that c	aused the death.	Ba Do not enter t	ltimor	e MD	21201 ardiac or respiratory a	arrest, shock,	, or heart	Approximate Inte	rval
Physician /Medical		failure. List only or	ie caluse on ea	ch line. Peritonitis								Between Onset a Death	and
Examiner		Immediate Cause (Final or condition resulting in			consequence o	f):							
	_	Sequentially list condition	ons,	Intestinal p	erforation	f).							
	nine	if any, leading to immed cause. Enter Underlying (Disease or injury that in	Cause C		on of hermat		hrough ab	dominal sui	gidal scar				
ed ssit	Examiner	events resulting in death	n) Last	Due to (or as a	a consequence o	f):							
O,  e be evecuted ysician and burial - transit	edical	UNPENDED	d.	AMENDED						· -			
760, cate by physic	/Me	IF FEMALE: 23b. Was decedent preg	nant in the		autcome of preg			. 🖂 .			Date of deliver	-	
: <b>6876</b> certificate ending phy	Physician/M	past 12 months?	nant in the	1 Live b	oirth nant at time of de		etal death ther <i>(Specify</i> ,		pregnancy	Mo	onth	Day Year	
Box e death c the atten	ysi	1 Yes 2 No 9	<b>✓</b> Unknown	9 Unkno	own	٥ ٥	ther (opcomy,						
of Vital Records, P.O. Box 6876( ing Physician: The law requires that the death certificate After this certificate has been signed by the attending physimeral director, page 2 should be detached for use as the b	by Pł	Part II. Other significar	t conditions	contributing to	o death but not r	esulting in the	underlying ca	use given in Pa				the cause of death?	
S, P luires t en sign	ed t			<del> </del>					24a. Wa			utopsy findings avail	
of Vital Records, B Physician: The law require ther this certificate has been is neral director, page 2 should be	Completed	·			-				au	topsy rformed?		completion of cause	
Rec The I	Con								1 ✔ Ye		1 🗸 Y	es 2 No	1
ician:	Be	25. Was case referred to examiner?		lospitat:	Inpatient 2	ER/Outpatien		Othor	(Check only one)  Nursing Home 5	Pasidence	e 6 🗸 Othe	er: Scana	-
1 of Vi 1 ng Physia After this	٠.	1 Yes 2	No	28a. Date (Month		28b. Time of	h	Injury at Work		e how injury		1. Scerie	
ond ng ath the funn	tion	1 Natural 5	Pending		n, Day,Year)		1	Yes 2	No				
Division Hospital or Attend to 24 hours after death Funer I Director:	Certification:	2 Accident 3 Suicide 6	Investigation Could not	28e Plac	ce of Injury - At h	ome, farm, stre	et, factory, of	fice building, et	c. 28f. Location		Number or R	ural Route Number,	City
Div ospital c hours at uner 1 B	Serti	4 Homicide	determined		1				or town	i, State)			
		29a. Certifier (Check only one) 2 Med	tifying Physici	an: To the be	st of my knowled	lge, death occu	irred at the tin	ne, date and pla pinion, death oc	ace, and due to the ca curred at the time, da	ause(s) and rate and place	nanner as sta	rted ne cause(s)	
To the within To the Complet	Medical	29b. Signature and title		and manner s	stated.			icense number				onth, Day, Year)	
		ALINT	> '					D.C.M.E.		1.	per 26, 200		
		30 Name and address of person who completed cause of death (Item 23a)											
		Ana Rubio MD					Street, Ba	timore, MD	21201				
	ate	31 Date filed (Month, D	ay, Year) 3 2006	32. R	egistrar's Signati	ure	3.00						
Regist	rai	NUVI	0 2000	A STATE OF THE PARTY OF THE PAR	Statement on .	7							

State of Maryland / Department of Health and Mental Hygiene 11 35675 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** tober Charles Feick /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner future Care Charles Village Baltimore Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1**∑**M 2□F Yrs. 66 Oct 20, 1940 Pennsylvania Director 213-38-4322 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural; or items 23a or 28a-f ehow any injury or other fraumatic event, the Medical Examination and once. 1√2 Yes 2 □ No MD Baltimore Director 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? 2327 N. Charles Street 21218 **IISA** Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify:white 1 ☐ Yes 2X No Specify: ۾ 3 ☐ Widowed 4 🎇 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) unk unk 18 Mother's Name (First, Middle, Maiden Sumame) unk unk 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Future Care Charles Village 2327 N. Charles Street Baltimore, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation & MOther (Specify) in state 21. Signatur of Finery Service License Director s 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease of condition resulting in death) renal railure **Physician** 10 day /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinitediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dub to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MELLITUS 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy performed? 1 Yes 2 No Division of Vital the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifica : After this certification is funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 035102 DMM) 30) Name and address of person who completed cause of death (Item 23a) (Type, Print) north CHARLES Street Baltimore Maryland HILAMY DON'M.D 5901 31. Date filed (Month, Day, Year) NOV 1 3 2006 32. Registrar's Signature State Gosses

DHMH 17 Rev 1/2001

Registrar

06-08249 Clinetta Freeman

### Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State 2006 35676 Certificate of Death Registrar Reg. No Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Medical Examiner Clinetta Month Day October 31, 2006 Freeman 2212 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Fort Washington Medical Center Fort Washington Prince George's 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Months Days Hours 579-25-6587 10-28-1994 Country) D.C. Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits or items 23a or 28a-f show notified at once, Maryland | Prince George's Oxon Hill 1 X Yes 2 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country ā 140 South Huron Drive 20745 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) must be Race - American Indian, Black 1 🔆 Never Married 2 Married Armed Forces? Yes it: If item 27 is marked other than "natural", of other tranmatic event, the Medical Examiner is Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify \$ **Black** Specify 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) ges I and 2 should be filed within 72 l of Health and Mental Hygiene College (1-4 or 5+) Public School Baltimore, MD 21215-0036 7th Student Prince George's 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Clinton L. Freeman Jennifer M. McGinnis 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, If item 27 is Clinton L. Freeman / father 140 South Huron Dr. Oxon Hill, Maryland 20745 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State 1 🔀 Burial 2 Cremation 3 Removal from State crematory or other place) mportant; Cedar Hill Cemetery 11-08-2006 Suitland, Maryland Donation 5 Other Specify: Signature of Funeral Service Licensee 22. Name and Address of Facility Mare Hedgman Cedar Hill FH 4111 PA., Avenue Suffland, MD Part I Enter the disease. r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one wise on each line Approximate Interval /Medical Between Onset and Peritonitis Examiner Immediate Cause (Final disease Death or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death sician/Medical X UNPENDED - burial -#23a.27. perME Box 68760, IF FEMALE phy the b 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 23d. Date of delivery Live birth past 12 months? Fetal death 3 Ectopic pregnancy Month Dav Year Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? ğ Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available this certificate has autopsy prior to completion of cause of performed? death? ✔ Yes 2 1 🗸 Yes 25. Was case referred to medica Be 26 Place of Death (Check only one) examiner? Hospital 1 Inpatient 2 V ER/Outpatient 3 1 V Yes DOA Nursing Home 5 Residence 6 After 28a. Date of Injury (Month, Day,Year) Manner of Death Certification: 28c. Injury at Work? 28d Describe how injury occurred 1 X Natural Director: the Pending 1 Yes 2 No Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 1, 2006 30 Name and address of person who comulated cause of death (Item 23a) Tasha Greenberg MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State Registrar

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**ORIGINAL** 

ype of Finit in black indelible lik. Ensure All Copies Are Legible.	
State of Maryland / Department of Health and Mental Hygien 006	3567
Certificate of Death Reg. No.	

Physician /Medical
Examiner
Euporal

For State Ragistrar

1-

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked other then "natural; or Itama 23 or 28s-f show early injury or other traumatic event; Ita Modical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

11:45 p.m.

NOVEMBER 2, 2006

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificete hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

MARGARET FOX

1. Decedent's Name (First, Middle	e, Last)				2. Date of Death		3. Time of Death			
Margaret J.	Fox				Nov.	2 2006	11:45p			
4a. Facility Name (If not institution	n, give street and number)		4b. City, Town, or Location of Death 4c. County of Death							
Stella Maris			Timoni	ore						
5. Social Security Number	6. Sex 7. Age	(In yrs. last birthday	Months Days	If Under 24 Hrs Hours Min	(Month, Day,	Year) 9. Birt	thplece (State or Foreign			
213-30-9141 Usual Residence of Decedent		72 Yrs.			01-23	<b>-</b> 1934	MD			
10a. State 10b. County		10c. City, Town or L	ocation		——————————————————————————————————————		10d. Inside City Limit			
MD Bal		1 ☐ Yes 2X N								
10e. Street and Number	. II. III. I	mand	allstown 10f. Zip Code	1	10	g. Citizen of What Co	ountry?			
3812 McDonog	sh Road		211	.33		USA				
11. Marital Status	12. Was Decedent E	ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba		Specify Yes or No-	14. Race - Ame				
1 Never Married 2 Marr	If Vac Cina	0	1 ☐ Yes 2 ☒ No	Specify:	riouri, oto.)	Black, Whit Afr	ican-			
3 Widowed 4 Divorced	Year or Dates:					Ame	rican			
15. Deceden (Specify only highe	it's Education st grade completed)	(Giv	edent's Usual Occupa e kind of work done o DO NOT use retired	during most of we	orkina	6b. Kind of Business/				
15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 9th  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Self-Employed  Domesticated Engineer										
DOMESTICATED Engineer  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)										
James Carpenter  18. Mother's Name (First, Middle, Maiden Sumame)  Ella McKinney										
19a. Informant's Name/Relations		19b. Maii	ing Address (Street			City or Town, State, 2	Zip Code)			
Vernita Humph			2 McDone							
20a. Method of Disposition	,	20b. Place of Disp	osition (Name of omatory or other place	En Log	Date 20	11stown, Oc. Location - City or				
1 🖾 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S			matory or other plac 1em. Parl	Θ)		odlawn,				
21. Signatur of Fin	jig Me			ss of Facility W	vlie F/H	P.A. of	Balto.			
AMM	MI	9	200 Libe	rty Rd	., Randa	llstown.	MD 2113.			
232 Part 1. Enter the disease, or	r complications that caused only one cause on each line	the death. Do not er					Approximate Interval Between			
Immediate Cause (Final disease or condition	a LIVER DI						Onset and Death			
Sequentially list conditions, if any, leading to immediate cause. Enter Unionlying Cause (Disease or injury that initiated events resulting in death) Last	С.	consequence of):								
	d									
d										
9 Unknown Part II. Other significant condition	ons contributing to death bu	t not resulting in the	underlying cause give	en in Part I.		cco use contribute to	the cause of death?			
		<u> </u>			24a. Was an	24b. Ware an	itopsy findings available			
					autopsy performe	prior to death?	completion of cause of			
25. Was case referred to medica	1			Of Place of S	The second second	No 1 ☐ Yes	2 No			
examiner?	Hospital: 1 Inpatier	nt 2 ER/Outpatie	ent 3 DOA Othe		ath Check on one		cify) HOSPICE			
	28a. Date of Injury (Month, Day		of 28c. Injury Work	4   Nursing	28d. Describe how		ciry) HUSPICE			
27. Manner of Death  1 X Natural 2 Accident investi 3 Surcide 6 Could 4 Homicide		ry - At home, farm, s (Specify)	treet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ural Route Number,			
29a. Certifier 1 X Cartifyin	ng Physician: To the best of Examiner: On the basis of and manner stat	examination and/or i	th occurred at the tim	ie, date and plac pinion, death occ	e, and due to the cau urred at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)			
29b. Signature and title of certifie	r )		29c. License	1372		d. Date signed (Monti				
	Examiner: On the basis of and manner stat	examination and/or i	29c. License	oinion, death occ	urred at the time, dat	e and place, and due d. Date signed (Monti	to the cause(s)			

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Guntharp Cleo Vovember /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Grener Tas MARYLAND Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 6-3-1915 Birthplace (State or Foreign Country) **Funeral** 1√2 M 2□ F Days Hours 91 Director N.C. 212-07-2698 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ehow other traumatic event, the Medical Examiner roust be notified at Director 1 TYYes 2 □ No Md. Baltimore NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or USA 2507 Linden Avenue 21217 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No þ Specify. Specify. 3 ☐ Widowed 4 ☐ Divorced Black "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) Disabled NA 12th grade permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
important: if Item 27 1e marked othe
any injury or other traumatic event,
subca. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Guntharp Lula Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ew 2418 Ridgley Street, Baltimore, Md.

20b. Place of Disposition (Name of cametery, crematory or other place)

Date 20c. Location - Ci Thomas Atkins Nephew timore, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Carmel Cem. 11-11-06 Dundalk, Md. 21. Signature of Funeral Service License 22. Name and Address of Facility March F.H. East 1101 E. North Ave., Baltimore, Md. 21202 23a. Part / Enter the disease, or complications that caused the shoot, or heart failure. List only one cause on each line. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate espiratory Arrest with Right Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** TEURAL. EFFUSION /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the burial-transit the Hospital or Attending Physician: The law requires that the deeth certificate be executed Kenal Due to (or as a consequence of): physicien Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ icate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient this 3 DOA Medical Certification; 27. Manner of Death 28a. Date of Injury (Month, Day Year) After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred s effer dee. rai Director: After 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours of To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 10 29d. Date signed (Month, Day, Year) M. Meratee 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 egistrar's Signature State Registrar

DHMH 17 Rev 1/2001

			_ Stete	ate of Maryland		rtment of He			200	6 35679
Ė	Physicia	an an	1. Decedent's Name (First, Middle, Last)		Cer	incate of L	zeau i	2. Date of Dea	Day	3. Time of Death 3:30a м
	/Medic Examin	al	Robert L. Guer			4b. City Town, or	Location of Dear		11 2006	
	Funeral Director		5. Social Security Number 6. Sex 391-24-7441	7. Age (In yrs. las 2□F		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		, Year)	9. Birthplace (State or Foreign Country) WISCONSIN
	show	or	Usual Residence of Decedent           10a. State         10b. County           MD         Baltin		Town or Loc					10d. Inside City Limits 1 ☐ Yes 2 XNo
	with the N e or 28a-f be notifi	Director	10e. Street and Number 617 Virginia Av	⁄e.		10f. Zip Code 2122	1		10g. Citizen of Wh	nat Country?
35	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "neturel", or Items 23e or 28e-f show event, it. M. dical Examinar must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married	Vas Decedent Ever in U.S. rmed Forces?		Vas Decedent of His Yes, specify Cubar		Specify Yes or No- to Rican, etc.)		- American Indian, , White, etc. White
9500-61212	filed within 72 hou Hygiene. other than "neture ant, 11, 12, or call	Completed	15. Decedent's Educatic (Specify only highest grade college of the Elementary/Secondary (0-12)	n npleted) College (1-4or 5+)	(Give I life. D	ent's Usual Occupa kind of work done d OO NOT use retired) ral Fore	uring most of wo	orking	16b. Kind of Bus	iness/Industry rn Stainless
Maryland	should be filed nd Mental Hygi marked other imatic event, I	To Be C	17. Father's Name (First, Middle, Last)  Leslie Lee Guer	ndt				me <i>(First, Middl</i> e, e Werde)		)
Mar	and 2 should ealth and Men n 27 is marke ser traumatic		19a. Informant's Name/Relationship (Type, Janet Hughes /da			g Address (Street a 30 King:				itate, Zip Code) MD 21220
Baltimore,	of H		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ Remo  4 □ Donation 5 □ Other (Specify)	val from State HO	ce of Dispos metery, crea LY H	sition (Name of natory or other place III Ceme	etery	Date 11/15/06	20c. Location - C 5 Balti	City or Town, State  MOre MD
Balt	permit. Page Department of Importent: If eny injury or		21. Signature of Fan (al Service Licensee)	anuly }			y Funei	cal Home	e of Es	Balto. MD sex 21221
b	Physician		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one complete the complete complete the complete condition resulting in death)	ons that caused the death.	Po not ente	er the mode of dying	allure	c or respiratory an	est,	Approximate Interval Between Onset and Death
760,	/Medical Examiner  hystcian and the priral-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	Que to (or as a conseque	4000	re xthy				
O. Box 687	The law requiras that the death cartificate be axeculed title has been signad by the attending physician and oase 2 should be detached for use as the burial-transit	Physician/Medlo	in the past 12 months?	f yes, outcome of pregnan 1 □Live birth 2 □ Fetal c 4 □ Pregnant at time of dea 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery th Day Year
ds, P.	uiras that l signad by id be deta		Part II. Other significant conditions contrib	uting to death but not result	ting in the ur	nderlying cause give	n in Part I.	in . 1		oute to the cause of death?
Records,		Completed by	Africal Filonillation	٦, ٧		/ 1		24a. Was a autop perfor 1 Yes	med de	ere autopsy findings available ior to completion of cause of sath?  Yes 2 No
f Vital	Physicien: The lithis certificate had director, page	To Be	25. Was case referred to medical examiner? 1 Tyes 2 No Hosp	ital: 1 Inpatient 2□E	R/Outpatien	t 3 DOA Othe	AC.	eath (Check only or Home 5 - Resid		(Specify)
Division of	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.		Natural 5 Pending 2 Accident investigation	8a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	at ? ∕es 2 □ No	28d. Describe h	ow injury occurre	d
DIX.	To the Hospitel or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification;	3 Suicide 6 Could not be 4 Homicide determined	<ol> <li>Place of Injury - At horn building, etc. (Specify)</li> </ol>		eet, factory, office		28f. Location (S City or Tow	itreet and Number n, State)	r or Rural Route Number,
	he Hospi in 24 hou he Funer pletely fill	edical		on: To the best of my know On the basis of examination and manner stated.		estigation, in my op	pinion, death occ	urred at the time, o	date and place, ar	nd due to the cause(s)
ł	To the within 7 To the comple	Σ	29b. Signature and title of certifier M	2		29c. License				(Month, Day, Year) , 11, 2006
	V		Name and address of person who comp	eted cause of death (Item	23a) (Type, YUK)	Print) 54.J	rive			ld 21237
**	Sta Regist		31. Date filed (Month, Day, Year) NOV 1 3 2006	32. Registrar's Signato	1 /	next?			J	

		I	State of Maryland / Der 1- State Amend item#18,19a, perFH,0861,11/13/06	partment of Health and Mental H	ygiene2006 35680
			Decedent's Name (First, Middle, Last)	2. Date of	Death 3. Time of Death
	Physici /Medio Examir	cal	MARCIE SATTRA  4a. Facility Name (If not institution, give street and number)	GOLD Month Ab. City, Town, or Location of Death	BER 07, 2006 \S:56 M  4c. County of Death
	LAGIIII	ICI	THE JOHNS HOPKINS HUSPITAL	BALTIMORE CITY	N/A
	Funeral Director		5. Social Security Number  166-34-0784  6. Sex 1 M 2 F 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. 04/2	Birth Day, Year)  9. Birthplace (State or Foreign Country)  PA
	land		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits
	the Marylan 28s-f ehow	ctor	MD HOWARD COL	_UMBIA	1 ☐ Yes 2 📈 No
	with the	Funeral Director	10e. Street and Number	101. Zip Code	10g. Citizen of What Country?
	ms 23	neral	11301 RIDERMARK ROW           11. Marital Status         12. Was Decedent Ever in U.S.         13	21044  3. Was Decedent of Hispanic Origin? (Specify Yes or	No- 14. Race - American Indian,
21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "naturel, or items 23s or 28s-f ehow other traumatic svent, the Medical Examinar must be notified at	þ	1 Never Married 2 Married 1 Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes 2 No Specify:	Black, White, etc.  Specify: WHITE
15-	in 72 l	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of working . DO NOT use retired)	16b. Kind of Business/Industry
	filed with Hygiene other the	Com	Elementary/Secondary (0-12) College (1-4or 5+) 2 PR(	OPRIETOR	TELEMARKETING
and	tal Hy oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Midd	,
Maryland	should nd Mer marke umatic	٦ و		HIEKEN EDITHE Edythe  iling Address (Street and Number or Rural Route Num	LESSER
	and 2 saith a n 27 is		EARRY SCHIEKEN / BROTHER 113	301 RIDERMARK ROW - COLU	
Baltimore,	permit. Pages 1 and 2 s Depertment of Health ar Importent: If I tem 27 is any Injury or other trau		I Dutial 2 Dicternation 3 Directional from State	ematory or other place)	20c. Location - City or Town, State
ij	ertmer ortent Injury			SERVICE CORP 11/10/06  22. Name and Address of Facility SQL LEV	TOWSON, MD
Ba	permit. Depertimport any inj		and	8900 REISTERSTOWN ROAD	INSON & BROS., INC. - PIKESVILLE, MD 21208
			23a. Part1. Egrer the disease, or complications that caused the death. Do not e shock or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or respiratory	Approximate Interval Between Onset and Death
)	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		24 hours
	Examiner		Due to (dr as a consequence of):		
	ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		
8760,	cate be executed physicien and the buriat-transit	dical Ex	Due to (or as a consequence of):  d		
9	ding pl	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		
. Box	The law requires that the death certific to has been signed by the attending page 2 should be detached for use as	by Physician/Me	250. Was decedent pregnant in the past 12 months?  1 ☐ Live birth 2 ☐ Fetal death 3  1 ☐ Vas 2 M No.  4 ☐ Pregnant at time of death 5	☐Ectopic pregnancy ☐ Other (specify)	23d. Date of delivery  Month Day Year
P.0	of the d by the etache	Phys	9 ☐ Unknowh		
	signed d be d	d by	Part II. Other significant conditions contributing to death but not resulting in the		d tobacco use contribute to the cause of death?  Yes  Unknown
Records,	s been	olete		24a. W	
		Completed		au	topsy prior to completion of cause of death?
Vital	Physician: The I this certificate har ral director, page	Be	25. Was case referred to medical examiner?	26. Place of Death (Check onl	y one)
o o	Phys er this eral dil	n: To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 28d. Describ	esidence 6 Other (Specify) e how injury occurred
sion	Attending I r death. ector: After by the funer	atlo	2 Accident investigation	Work? M 1 □ Yes 2 □ No	
Division	or Atte	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		(Street and Number or Rural Route Number, Fown, State)
_	To the Mospital or Attending Ph within 24 hours efter death. To the Funerel Director: After th completely filled in by the funeral	edical Co	29a. Certifier (Check out) one)  1 Certifying Physician: To the best of my knowledge, dea (Check out) 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and due to the investigation, in my opinion, death occurred at the tim	ne cause(s) and manner as stated. e, date and place, and due to the cause(s)
	within To th Comp	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	~		Ja Jany MEDICAL DOCT	OR RES-000	November 67, 2006 BOUTIMENT 21287
/	0 1		30. Name and address of person who completed cause of death (Item 23a) (Type GIA LANDRY THE SOUNDS HOPKIN	s, Print) S HOSPITAL GOO WORTH L'	BALTIMORE 21287
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	- 1000 100 100	The state of the s
DH	Registi MH 17 Rev 1/2		NOV 1 3 2006	(act)	
חט	iz nev 1/2	501	ORI	GINAL	

James Thomas Hunter, III

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar			Reg	<sub>3. No.</sub> 2(	006	3	568			
Physicia edical Exami		Decedent's Name (First, Middle,La  TAMELO FILLONIA						Date of Death Month November			3. Time of D 1507 h	
···		JAMES THOMAS  4a. Facility Name (if not institution, gi		III	4b. City	, Town, or Locat		November	3, 2006 4c. County of	of Death	1507 111	
		Johns Hopkins Bayview I	Medical Center		Balt	imore			N/A			
Funeral		Social Security Number     6. S		n yrs last bir					(MM/DD/YYYY	9. Birth	place (State	e or
Director		220-23-8600 1	X M 2 F	18	Yrs. Mor	oths Days H	ours Min.	06/26	/1988	Cour	MARII htry)	TAND
aux		Usual Residence of Decedent  10a. State 10b. County	110	c. City, Town	or Location						IOd Inside	City Limits
<b>*</b> .		MD N/Z		o. org, roun		MORE C	ТТҮ				1 X Yes	. ,
he Maryland or 28a-f show	Director	10e. Street and Number				ip Code		100	g. Citizen of Wh			
e le	Dire	1911 WOODBOU	JRNE AVENU	E		2123	9		USA		,	
n with the ms 23a be noti	uneral	11 Marital Status	12. Was Decedent Ev			dent of Hispanic	Origin? ( Spec		14. Race	- America	an Indian, B	lack,
or ite	Fun	1 X Never Married 2 Marrie	1 Yes 2 X	No		cify Cuban, Mexi		ican, etc.)	White	e, etc.		
s after ral",	þ		If Yes, Give Year or Dates:	-1d) [40.		2X No spe			Specify:		ACK	
5-0036 lled within 72 hours Hygiene tother than "natur the Medical Exam	Completed	15 Decedent's Education (Specify of Elementary/Secondary (0-12)	College (1-4 or 5+)		Decedent's Usu during most of w				16b. Kind of Bu	siness/Ind	dustry	
336 thin 7 ne r than	nple	12TH			FOOD S	ERVICE	WORKE	ER	BURGE	R K	ENG C	ORP.
5-0 led wi Hygie other	-	17. Father's Name (First, Middle, Las	it)			18.Mo	ther's Name (F	irst, Middle, M	aiden Surname)			
21215-0036 uld be filed within 72 hou Mental Hygiene marked other than "nat	Be	JAMES THOMAS	HUNTER,	JR.			YOLANI	DA R.	ORAM			
MD 2  od 2 shoul  lith and M  o 27 is m  aumatic of	٦	19a. Informant's Name/Relationship ( JAMES T. HUNTE			b. Mailing Addre						Zip Code) 21	239
and 2 lealth tem 2 traun		20a. Method of Disposition	SK, JK/ FA		1911 of Disposition (N	ame of cemetery	URNE A	Date B	AL'I' I MO 20c. Location -	RE,	MD own, State	
Baltimore, MD 2 seemit. Pages 1 and 2 shou Oepartment of Health and N important: If item 27 is nijury or other traumatic		1 X Burial 2 Cremation 3		KING	tory or other place MEM.	PARK	11/1	0/06	WINDS	OR N	ATT.T.	MD
Baltin permit. P. Departme Importan injury or		4 Donation 5 Other Specification 21. Signature of Funeral Service Lice		<b></b>		nd Address of Fa	100					
Dep Per		( Julian .	N. Nou	1111-		LIBER	HC	OWELL :	FUNERA	L H( ∆ፒጥ1	OME 2	1207 MM
Physician		231 Part . Enter the disease, or com- failure. List only one cause on e	iplications that caused the	death Don	ot enter the mod	e of dying, such	as cardiac or r	espiratory arres	st, shock, or hea	nrt	Approxima Between C	ite Interval
/Medical Examiner		Imme ate Cause (Final disease a	Contact Gunshot		Head						De	
		or condition resulting in death)	Due to (or as a consequ	ence of):								
	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	ience of):								
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequ	ionoo of):								
ecuted and transit		events resulting in death) Last	d.	ence or).								
9 2 1	/Medical	UNPENDED	AMENDED				-					
8760, ificate be exe ng physician a	/Me	IF FEMALE: 23b Was decedent pregnant in the	23c. If yes, outcome						23d Date of	delivery		
r 68 certif		past 12 months?	1 Live birth 4 Pregnant at tim	F -1 11	Fetal deat		topic pregnanc	У	Month	Da	у	Year
Box e death c the atten ed for us	Physicia	1 Yes 2 No 9 Unknow			5 Other (S	эеспу)						
i, P.O. Box 68760, ries that the death certificate be e. signed by the attending physician be detached for use as the burial		Part II. Other significant conditions	contributing to death be	ut not resultin	g in the underly	ng cause given ii	n Part I.		acco use contril			
S, P	ed by							1 Yes	2 <b>V</b> No 3	Probal	oly 4 L	Jnknown
ords, Iw requir as been s	plet							24a. Was ar autopsy	/ pi	rior to cor	psy findings npletion <b>of</b> c	
tal Reco	Completed							perform 1 Yes 2		eath? Yes	2	No
tal F cian: certifi ector.	Be	25. Was case referred to medical examiner?	Hospital:			26 Place of De		ly one)				
f Vil Physic er this ral din	ဥ	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient		utpatient 3	DOA Other			esidence 6	Other:		
Division of Vital Records, rs at or Attending Physician: The law requiring a directors. The transport of the former of the funeral director, page 2 should be din by the funeral director, page 2 should be din by the funeral director, page 2 should be director.	ion:	1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year) Nov 2, 2006	285.	Time of Injury 4 hrs	28c. Injury at V		ubject shot	w injury occurre self	ed		
isio Atter er dear rector	icat	2 Accident Investiga	28e Place of Injure	v - At home fa	arm street facto			Rf Location (St	reet and Numbe	r or Rura	Route Nun	mber City
Divisior Hospital or Attent 24 hours after death Funeral Director: tely filled in by the	Certification:	3 ✓ Suicide 6 Could no determine	t be			7,		or Town, Sta				naci, ony
el 4 h		20a Cortifies	cian: To the best of my ki		ath occurred at t	he time, date and						
To the Howithin 24 h To the Fur completely	Medical	_ = ===================================	er: On the basis of examin and manner stated.	ation and/or i	investigation, in I	my opinion, death	h occurred at th	he time, date ar	nd place, and du	ue to the	cause(s)	
- > - 0	ž	29b. Signature and title of certifier	10		2	9c. License num	ber		29d. Date signe			)
		4 M	. (1			O.C.M.E.			November 4	4, 2006		
2		30. Name and address of person who Jack Titus MD. Deputy	completed cause of deal Chief Medical Exa	,	11 Penn Str	eet Baltimor	e MD 212	<del></del>				
<u> </u>	tate	31. Date filed (Month, Day, Year)	32 Registrar's		A CITI OU	CCI, Dailli 101	C, IVID 2 120					
	trar		06 Magaza	S. C.	South !							

			1 - For State Registrar	State of Ma	iryland / Depa <i>Cei</i>	artment of H <i>tificate of L</i>		Mental Hyg	giene Reg. N2 () (	)6	35682
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ith		3. Time of Death
	hysici /Medio		Grace Lydia Horn	er				Novembe	r 10, 2	:006	1:40 A <sup>M</sup>
E	Examin	er	4a. Facility Name (If not institution, give st Bayview Care Center			4b. City, Town, or Baltimore	Location of Death		4c. County		
			5. Social Security Number 6. Sex		(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		0 Rietho	In an (State or Foreign
	ineral rector				90 Yrs.	Months Days	Hours Min.	Month, Day Dec. 19	/ Year)	Maryl	lace (State or Foreign try) and
D			Usual Residence of Decedent					DCC. 13	7.5.5		
arylai	show at a	5	10a. State 10b. County		10c. City, Town or Lo					10	0d. Inside City Limits 1 ☐ Yes 2 2 No
the M	28a-1	ecto	Maryland Baltimore  10e. Street and Number		Middle Ri	10f. Zip Code			10- Citizen of 1	Afb a A O a u a	
With a	3a or	Dir	3700 White Pine Roa	d, Apt. (	C	2122	0		10g. Citizen of \ U.S.A		try :
death	ms 5	Funeral Director		2. Was Decedent E Armed Forces?		Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No-	14. Rac	e - America	
III ( Z I Z I 3-0030 be filed within 72 hours after death with the Maryland Ital Hygiene.	od other than "naturel", or items 23a or 28a-1 show event, the Medical Executes count be notified at	by Fu	1 Never Married 2 Married	1 ☐ Yes 25N If Yes, Give	0	l □ Yes XXNo	Specify:	rican, etc.)	Specify	ck, White, e	_
P nor	turel'	ed b	3€Widowed 4 ☐ Divorced  15. Decedent's Educ	Year or Dates:		ient's Usual Occupa	ntion	1		AATIT	
<b>7</b> oic 1	Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5-	(Give	kind of work done of DO NOT use retired,	furina most of work	ing	16b. Kind of B	1214622/110	ustry
d with	er the	Com	6	College (1-40) 3-	Homema	aker			Own Ho	me	
D ed la	d oth event	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	•		•	
Z should be filed within and Mental Hygiene.	narke	မ	Charles E. Foulke	- Deinel				stella S			
Man Ith an	27 Is r treur		19a. Informant's Name/Relationship (Type Betty Sheffer (Daug			g Address <i>(Street</i> a Kittyhawi					
s 1 ar f Hea	other		20a. Method of Disposition	· · · ·	20b. Place of Dispo-	sition (Name of			20c. Location -		
Page Page	iry or		1 X Burial 2 ☐ Cremation 3 ☐ Re  '4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Parkwood	natory or other place Cemetery	1	13.2006	Baltimo	re N	Maryland
permit, Pages 1 and 2 should be Department of Health and Menta	Importe any inju once.		21. Signature of Fune al Service Cicensee	,		. Name and Addres					
<b>.</b> 20.	= = 9		1			1407 Old 1	Eastern <i>P</i>	venue,	Essex,	Maryl	and 21221
			23a. Part1. Example disease, or complic shock or heart failure. List only one	ations that caused cause on each lin	ө.	11 - 0	6321	1	rest,		Approximate Interval Between Onset and Death
	sician edical		Immediat Cau (Final disease dition resulting in death) a.	Serile	diment	ia ali	sheere	20 4	me		Oliset and Death
	miner			Due to (or as a	consequence of):	<	,	(			
P 1		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to or as a	consiquence of					-	
cuted	nd transil	Examiner	Cause (Disease or injury that initiated events								
, e ex	cian a	i Ex	resulting in death) Last	Due to (or as a	consequence of):						
DIVISION OF VITAL INCOMINGS, F.O. BOX 00100, for the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.	g physician and as the burial-transit	edicai	d.								
centif	nding use a:		IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome o					23d Dat	te of deliver	0/
death	been signed by the attendin should be detached for use	Physician/M	in the past 12 months?	1☐Live birth 2 4☐Pregnant at t		Ectopic pregnancy Other (specify)			Mo		Day Year
at the	by th	Phys	9 □ Unknown	9□ Unknown							
<b>.</b> 88 h	igned be de	by	Part II. Other significant conditions cont	ibuting to death bu	t not resulting in the ur	iderlying cause give	en in Part I.				e cause of death?
nbe.	plnodi	eted	aco paroses					1 L Y	es 2 No	3 Proba	ably 4 Minknown
yel er	y has	Completed	•					24a. Was a autops perform	sv r		psy findings available inpletion of cause of
1 : I	certificate has rector, page 2	e Co	25. Was case referred to medical		· · · · · · · · · · · · · · · · · · ·		OC Place of Death	1 ☐ Yes	2 No 1	I ☐ Yes a	2 🗌 No
yslcie	is cert direct	0	examiner?	spital:	nt 2 ER/Outpatient	t 3□ DOA Cthe	26. Place of Death	me 5 ☐ Reside		er (Specify	•
5 E	ector: After this certificate has by the funeral director, page 2	J: uc	27. Manner of Death  1 ★Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	28c. Injury Work	at	28d. Describe ho			
tendii leath.	for: A the fu	catio	2 Accident investigation 3 Suicide 6 Could not be			M 1 □ Y	res 2□No				
or At	Direction by	ertification:	4 Homicide determined	28e. Place of Injur- building, etc.	ry - At home, farm, stre . <i>(Specify)</i>	eet, factory, office		28f. Location (St City or Town	treet and Numb n, State)	er or Rural	Route Number,
spitel	filled	0	29a. Certifier 1 Certifying Physi	cieπ: To the best o	f my knowledge, death	occurred at the time	e date and place	and due to the co	ause(s) and ma	nner as ets	atod
To the Hospitel or Attendi	To the Funerel Discompletely filled in	edicai	(Check only 2 Medical Exemine one)	er: On the basis of and manner stat	examination and/or inv	estigation, in my op	inion, death occurr	red at the time, d	ate and place, a	and due to	the cause(s)
To #	comp	M	29b. Signature and title of certifier	1 -	_	29c. License			9d. Date signed		
			Druce U. Coro	th mi	0	D35	763	/	lovem	ber 1	0,2006
10	0		30. Name and address of person who com	pleted cause of de	ath (Item 23a) (Type, I	Print)	Δ	1 1	B	/:	0 1
	V Sta	te.	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	OKINS	Juyvia	Circle	Lolly	INDI	10,2006 reMd21234
F	ale Registr		NOV 1 3 200		J. B. Ag		•				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

amend Items 9 10e per ini 861 11-13-06 vt
State of Maryland / Department of Health and Mental Hygiene

					· y · a · i a · a	Certifica	te of Death		Reg. No. 2 0 0	)6 3	5683
			1. Decedent's Name (First, Middle, Las	it)				2. Date of De	eth Day	11	Time of Death
	Physici /Medic		EdWARD E.	HARMIS				oct	. 27	2006	10:05 pm
	Examin		4a Fecility Neme (If not institution, give			1		, or Location of Deet			
		Ť	Frederick Vill	A NUTSIN	3 Cent	ter		suille		timok	
	Funeral Director		5. Social Security Number 6. Sec. 2/6-/8-3388	ex 7. Age 7. Age	(In yrs. lest bin	Yrs. If Und Months	er 1 Year If Under 24 Deys Hours	Hrs. 8. Date of Bi Min. (Month, Di 08-0	th ay, Year) 8 - 1921	9. Birthplace Country)	(Stete or Foreign MD.
	pue ≱		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	n or Location				10d. lr	nside City Limits
	Mary	ō	MD		Balti	more				1:	Yes 2□No
	1 the	9	2714 end Number			10f. Z	ip Code		10g. Citizen of W	hat Country?	
	3a o	Funeral Director	<del>2417</del> Georgetown R	toad			21230	and the second	USA	A	
	deet deet	ner	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U,S.	13. Was Dec	edent of Hispanic Origin ecify Cuban, Mexican, F	? (Specify Yes or No	- 14. Race	- American In k, White, etc.	idian,
0200-91212	2 should be filed within 72 hours efter deeth with the Maryland and Mental Hygiene. Is marked other than "naturel; or items 23s or 28s-f show aumstic event, the Maccal Examiner must be notified at	by Fu	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 🕅 Yes 2 🗆 No If Yes, Give Year or Dates:	142-4	1□ Vos	2X No Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify:	1 .	te
0	72 ho	Be Completed by	15. Decedent's Ed (Specify only highest gre	lucation de completed)	16e.	Decedent's Us (Give kind of w	ual Occupation ork done during most of use retired)	f working	16b. Kind of Bu	siness/Industry	у
7	ithin	d d	Elementary/Secondary (0-12)	College (1-4or 5+					1	• 1 1	
2	filed w Hygier ther th	S	6	0	7	varehou		Name (First, Middle		illery	
ב	e d a b	Be	17. Father's Neme (First, Middle, Last)					nie Grime		9)	
Ž	should be f and Mental i marked of numatic eve	2	Charles Harmis	Fire Print)	10h	Mailing Addro	ss (Street and Number of			State Zin Code	(e)
<u>a</u>	ロミトラ		19a. Informant's Name/Relationship (7 Constance Harmis/				onesta Road				
a,	of Health of Health Item 27	ŀ	20a. Method of Disposition		20b. Place of	Disposition (N	ame of	Date	20c. Location -	City or Town, S	State
Baitimore, Maryland	permit. Pages Depertment of I Important: If Ite any injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Specify	r)		ry, cremetory or					
Bail	Dependit Dep		21. Signature of Funeral Service Licen	Wade, Dire	ctor		and Address of Facility Anatomy Boa lore, MD 21	ard 655 W. 1201	Baltimo	re Str	eet
			23a. Part. Enter the disease, or companies or heart failure. List only	plications that caused tone cause on each line	the death. Do	not enter the mo	ode of dying, such as ca	rdiac or respiratory a	rrest,	Inte	proximate erval Between
Top of	Physician		,							Ons	set and Death
Ž,	/Medical		Immediate Cause (Final disease or condition	9	Cardi	o My ope	ithy				
	E A COLUMN TO	<u>ا</u> يا	resulting in death)	Г	Due to (or as a	cosequence o	):				
	ed sit	Medical Examiner		b							
	end end end	xan	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury		ue to (or as a	consequence of	):			i	
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687	rificete be executed ng physician end es the bunel-trensit	뒿	resulting in death) Last	ь	oue to (or as a o	consequence of	):			i	
×	certii nding use e			d							11
Ď	etter d for	cla	Part II. Other eignificant conditions of	ontributing to death bu	t not resulting in	the underlying	cause given in Part I	23b. Did	tobacco use con	tribute to the	cause of death?
P.O. Box	the d by the echec	Physician/	Part II. Other eignineant conditions of	Sittibuting to death but	THOU TOSULATE II	T the underlying	oaddo gwori ii i' air i.		Yes 2□No		\~
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Division of Vital Records,	Attending Physician: The law requires that the deeth certificate be executed sr death.  ector: Atter this certificate has been signed by the ettending physician end by the inneral director, page 2 should be deteched for use as the buriel-trensit	Completed by						24a. Wa: perf	s an autopsy ormed?	availabl	utopsy findings le prior to tion of cause h?
æ	ne lan e has age 2	E C						10	Yes 2 No	1 □ Ye	s 2 No
a	ificet or, pe	O	25. Was case referred to medical				26. Place of	f Death (Check only			
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0	a Physerthis	2	27. Manner of Death	28a. Date of Injury (Month, Dey	(Year) 28b.	Time of	28c. Injury at Work?		how injury occurr		
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)ivis	or Atte efter de Directo I in by th	ertific	3 ☐ Suicide 6 ☐ Could not be determined		ry - At home, fa (Specify)	irm, street, facto	ory, office	28f. Location City or To	(Street and Number wn, Stete)	er or Runal Roi	ute Number,
_	To the Hospital or Attending Physician: The law within 24 hours effected.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical Certification:	29a. Certifier (Check only one) 2 Medical Exam	ysician: To the best of niner: On the basis of and menner state	examination an	e, death occurre	d at the time, date and pon, in my opinion, death	place, and due to the occurred at the time	cause(s) and ma date and place, a	nner as stated and due to the	l. cause(s)
	ithin the	Med	29b. Signature end title of certifier	dud tiletilet stat		2	9c. License number		29d. Date signed	(Month, Day,	Year)
	5 7 <u>8</u> 7 8		Daymora Mill	w MD			D47683		11/1/0	6	
			30. Neme end eddress of person who		eth (Item 23e)						
			Paymona Miller 25	Main Siver	+ Some	200 1	Pershabown	MD			
	Sta		St. Date filed (Month, Day, Year) NOV 1 3 20	Main Sweet	r's Signature	Bon M	th.				
	Regist	ar	NITIV I 3 ZU	UU Kan Soda	E 500	AND THE STATE OF T	F				1

State of Maryland / Department of Health and Mental Hygiene 35684 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day **Physician** October 14, Khin Htwe 2006 9:50 PM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 7748 Epsilon Drive Rockville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec 29, 1913 Birthplace (State or Foreign Country)
 Burma 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖾 F 92 Yrs. 215-96-3155 Director Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits r then "naturel", or iteme 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7748 Epsilon Drive 20855 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: burmese Completed by 3k Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill thent of Health and Mental H tant: If item 27 is marked off jury or other treumatic even Be U Po Maung ဥ Daw Ave Tha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kyi Kyi Tun/daughter 7748 Epsilon Drive Rockville, MD 20b. Pface of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State important: If any injury or once. 4 ☑ Donation S ☐ Other (Specify) 21. Signature of Euneral Service Ronald 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street S. Wade mm Baltimroe, MD 21201

26a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Baltimroe, MD 21201 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician gestive /Medical Examiner Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit DU tur that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Oron as Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown NA 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2. No 3 Probably 4 Unknown Completed | 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 86 26. Pface of Death (Check only one) Hospitaf: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No NA Director: / 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours e To the Funerel I completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HADYGROVE C+ RAMLETH SHAKIR MD 9019 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

MEND TIEM#5, perfet, G861, 1175, 706, WS

State of Maryland / Department of Health and Mental Hygiene Reg. No. 006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2<u>006</u> **Physician** NOV.8, EVELYN HERBERT 7:51pm/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Nursing Home Homewood Baltimore N/A If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 5. \$109°°46~1048 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 213/0/974 1 □ M 2 ☑ F 51 Director 23,1955 NewYork Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or Items 23a or 28a-f ehow event, the Medical Examinar must be notified at 1 √Yes 2 No Funeral Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 717 Druid Lake Drive U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 9th Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ould be f Mental I permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked c any injury or other traumatic ever sones. Willie Alston Juanita Oliver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Oliver/cousin 3823 Elmley Ave. Balto. Md 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Trinity Cemetery Nov.16,2006 Baltimore, MD 21. Signature of Eugeral Service Licensee 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 412 E. PRESTON ST. BALTO. MD 21213 23a. Part1. Enter the disease, or complications that cause at shock, or heart failure. List only one cause on each line the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician END STAGE DISGASE LIVER /Medical Due to (or as a consequence of): **Examiner** HEPATITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physiclan/Medical Examiner Due to for sels consequence of: The law requires that the death certificate be executed burial-tran the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has director, page 2 autopsy performed 1□ Yes 2☑No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Thursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Hospital or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No after death. 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) ATTENDING DOD 62 239. PHYSICIAN. NOVEMBER GOOD SAMARITAN HOSPITAZ. 30. Name and address of persop who completed cause of death (Item 23a) (Type, Print) NA 1N4 MAW 00, MD BALTIMORE 31. Date filed (Month, Day, Year) NOV 1 3 2006 32. Registrar's Signature State Registrar

			1 - State Amend item#10d,pe	State of Maryland erFH, G861,11/13/0	/ Depa 6 TC <i>er</i>	irtment of H tificate of I	lealth and M Death	lental Hygie	2008	5 35686
Н	Physici	an	1. Decedent's Name (First, Middle, Last)					Date of Death     Month	Day Ye	3. Time of Death
	/Medic			140				Nov		06 1205pm
	Examin	er	4a. Facility Name (If not institution, give s	17		4b. City, Town, or RANDALL	Location of Death		BALTIMO	
	-		NORTHWEST HOSPITAL  5. Social Security Number 6. Sex		st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign
	Funeral Director			<sup>7</sup> M 2□F 74	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y. 02/07/19:		Country) NY
	D		Usual Residence of Decedent						JZ	
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	Ne M	Director	Ma. Bestin	عدد ال	J. Mg.	a malls	<u> </u>		011 (116	<del>1.□Ye</del> s 2√No
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	within 72 hours after deeth with the Maryland ene. then "naturel", or feme 23e or 28e-f ehow the Modical Exercities mail be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	R 3. V	Vas Decedent of H	ispanic Origin? (Spe	ecify Yes or No-		American Indian,
9	or fter		1 Never Married 2 Married	Armed Forces? 1 ☑ Yes 2 ☐ No	li li	Yes, specify Cuba	in, Mexican, Puerto	Rican, etc.)		White, etc.
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21215-0036	e filed within al Hygiene. I other then 'vent, Ite Ma	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retired REPRESENT	•	W	HOLESALE	E SHOES
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<u>la</u> n	Aental Aental rked tic ev	To Be	LOUIS		HELLI	ER	ESTHER		Gl	LATTERMAN
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hyglene. Importants if item 27 is marked other then "natural", or fteme 23a or 28e-1 ehow any injury or other treumatic event, the Modical Examination relatived at ODGs.		19a. Informant's Name/Relationship (Type DINAH B. HELLER /	Ne, Print) WIFE	19b. Mailin 8002	g Address (Street & VALLEY MA	and Number or Rura NOR ROAD	#3-A - 0	WINGS M.	ILLS, MD 21117
Baltimore,	of Head		20a. Method of Disposition	con	ce of Dispon	sition (Name of natory or other plac		Date 20	c. Location - City	y or Town, State
Ē	Page ment ant: fi		1 Magazial 2 ☐ Cremation 3 ☐ Ri 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-	CONG.	11/10/	/2006 0	WINGS M	ILLS, MD
Salt	permit. Depertrimports eny injuncte.		21. Signature of Funeral Service License		22	. Name and Addres		LEVINSO		
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	Physician /Medical Examiner	iner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, I any, loading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	nce of):	enaci			•	Interval Between Onset and Death
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	thet bed by deta	by Ph	Part II. Other significant conditions con	tributing to death but not resulti	ing in the ur	nderlying cause give	en in Part I.	23e. Did tobac	cco use contribut	te to the cause of death?
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Division of Vital Records,	The law require ate has been si page 2 should I	Completed						24a. Was an autopsy performe	d? prior	e autopsy findings available r to completion of cause of th? Yes 28 No
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ů.	Jing F After Junere	lon	27. Manner of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injun Work		28d. Describe how	injury occurred	
isi	death. ctor: A	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hom-	o farm stre		Yes 2 □No	28f Location (Street	at and Number o	or Rural Route Number.
<u>&gt;</u>	efter Dire	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	io, iaini, siii	on, ractory, office		City or Town, S		Traiai House Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: cimpletely filled in by the	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the time restigation, in my op	ne, date and place, pinion, death occurr	and due to the caused at the time, date	se(s) and manne and place, and	or as stated. due to the cause(s)
	To the To the To the Second	Me	29b. Signature and title of certifier			29c. License	e number	29d	. Date signed (M	fonth, Day, Year)
	~		Clean de la companya			ח פ	9085	A	200	S- 2 /20-
j	1		30. Name and address of person who co	mpleted cause of death (Item 2	За) (Туре,					
0	Digital way or the		Alles I. Ch.	CUL A		EC   151	2. (	1200		4113)
	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 3 200	32 Registrar's Signatur	1	3433				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day CHAVON Y JETER Z:ZO PM 2006 NOVEMBER /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HARBOR HOSPITAL CENTER BALTIMORE N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State of Country) 08/23/1968 MARYLAND 6. Sex Birthplace (State or Foreign
Country) **Funeral** 1 M 2 XF 38 Director 215-86-9901 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show Director MD N/A Yes 2 □ No BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2628 RIDGLEY STREET 21230 USA itema 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pagas 1 and 2 should be filed within 72 hours after a Caperment of Haalth and Mantal Hygiena. Important: If item 27 is marked other then "natural" or iten any injury or other traumatic event, the Medical Examinar and 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FOOD SERVICE WORKER BURGER KING CORP. 11TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE JETER GWENDOLYN PRIDE ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA GRIMES / DAUGHTER 733 MC CAVE AVENUE, BALTIMORE, MD 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial ②☐Cremation 3 ☐Removal from State 4 ☐Donation 5 ☐ Other (Specify) 11/14/06 METRO CREMATORY CATONSVILLE, MD 21. Signature of neral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD of the disease, or complications that caused the death heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician DISSEMINATED ONE DAY INTRAVASCULAR COAGULOPATHY /Medical Due to (or as a consequence of): Examiner ACQUIRED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IMMUNODEFICIENCY SYNDROME HORE THEN S Due to (or as a consequence of). YEARS Examine or Attending Physicien: The law requires that the death cartificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 PNo 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 😿 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural daath. 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \( \text{Homicide} \) within 24 hours a To the Funeral 6 1 Certifying Physician: To the best of my knowledge death occurred at the time, late and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MP RESOOI NOVEMBER 1,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21225 FRANCOIS J. GREGOIRE, HARBOR HOSPITAL CENTER, 3001 5. HANGUEK, BALTIMORE, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 3 2006 And Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 35688 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** TOHNSON KEVIN 06:35 NOVEMBER 2006 5 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BACTIMORE CITY If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 XM 2 ☐ F 218-62-3568 50 Yrs. Director 2-20-1956 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene.
ant: If item 27 ie marked other then "naturel", or Iteme 23a or 28a-1 ehow ury or other treumatic event, the Madical Examinar must be inclified at 1X Yes 2 No Director Baltimore NA Md. 10f. Zip Code 21213 10g. Citizen of What Country? 10e, Street and Number N. Wolfe Street 1815 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black White etc. 1 ☐ Yes 2X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 € No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Keswick N.H. Laundry Dept. 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Johnson Colvin J. Vivian ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 1815 N. Wolfe Street, Baltimore, Md. Ricky Johnson Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it eny injury or o 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11-10-06 Dundalk, Md. Trinity Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East Wan 21202 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1101 E. North Ave., Baltimore, Md. Approximate Interval Between Onset and Death tmmediate Cause (Final **Physician** SEPSIS 8 hrs disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 1 YEAR VIH Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician thed for use as the buria Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown څ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed Ď 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy certificate 2. No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \( \) Nursing Home 5 \( \) Residence 6 \( \)Other (Specify) dir ٩ 1 Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After t 5 Pending investigation 1 Natural 1 Yes 2 No М 2 Accident Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after of Funeral Direc 4 🗀 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier PHYSICIAN NOURMBER 5, 2006 RES-000 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) JOHNS HOPKINS HOSPITAL, GOO NORTH WOLFE STREET, BALTIMORE, MARYLAND J. CE14 MATTHEW THE 31. Date fifed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** ANNA MAE MERCER JOHNSON 2:15 AM 08 06 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE CITY JOHNS HOPKINS BAYVIEW CARE CENTER BALTIMORE 8. Date of Birth (Month, Day, Ye JULY 21, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** Days Year) 1 □ M 2 🔀 F Months 212-18-4534 87 Director Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 □ No Director MD BALTIMORE ROSEDALE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21237 USA 4 NANCY COURT Funeral 14. Race - American Indian. 12. Was Decedent Ever In U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give X 1 □ Yes 2 No Maryland 21215-0036 Specify: þ BLACK 3 XWidowed 4 ☐ Divorced Year or Dates: 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the OFFICE ASSISTANT WIC d 2 should be filed w h and Mental Hygiei 7 is marked other tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BRICE DUDLEY GEORGIA RIDER ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2.
Department of Health an Important: if Item 27 is any Injury or other trau CAROLYN DAVID/DAUGHTER NANCY COURT BALTIMORE, MARYLAND Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS MEMORIAL PK. 11-14-06 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE. MARYLAND 21217 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): mellitu Examiner Sequentially list conditions, if any, leading to infinitediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed hupertension burial-trar (or as a consequence of) attending physician Physician/Medical the nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregnancy 0 Dav 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an has page 2 autopsy performed? Yes 2X1No certificate funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2X1 No 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) Division Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. after death. in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral L completely filled CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

le

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

0-1105

Wei

NOV 1 3 2006

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5505

ddress of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

29c. License number

0060052

Hopkins Bayview Circle

29d. Date signed (Month, Day, Year)

			For State Registrar	State of Maryland		nt of Health and lete of Death	Mental Hygier	711116	35690
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last)	Jackson			2. Date of Death Month November	2 9, 2006	3. Time of Death
9	Examin	er	4a. Facility Name (If not institution, give structure)  5. Social Security Number 6. Sex	L Soital Age (In yrs. las	Ba	Town, or Location of Deat  White Company of the Com	Date of Birth	4c. County of Death  9. Birth	olace (State or Foreign
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Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)	000	ce of Disposition (Na metery, crematory or the CPM	ame of other place)	10/06 Ca	Location-City of T	Maryland Maryland
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Division of Vital Records, P.O. Box 68	Attanding Physicien: The law requires that the death certificate be exideath.  actor: After this certificate has been signed by the attending physicien by the funeral director, page 2 should be deteched for use as the buria	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea 9 ☐ Unknown	death 3 Ectopic			23d. Date of delive Month	very Day Year
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Divis	To the Hospital or Attandii within 24 hours after death. To the Funeral Director; A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, larm, street, lacto	ory, office	28I. Location (Stree City or Town, S		ral Route Number,
	na Hoapl n 24 hou na Funer bletely fill	Medical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	er: On the basis of my know er: On the basis of examinati and manner stated.	viedge, death occurre on and/or investigation	ed at the time, date and plac on, in my opinion, death occ	ce, and due to the caus curred at the time, date	a(s) and manner as and place, and due	stated. to the cause(s)
	To the Comp	Σ	29b. Signature and title of certifier	- HONG L	EI, MD	89c. License number 89585	29d.	Date signed (Month	n, Dey, Year)
	3		30. Name and address of person who cor	mpleted cause of death (Item	23a) (Type, Print)	reneral X	bspital		
	St Regist	ate	31. Date filed (Month, Day, Year)	32 de strar's Signat	ule/	<b>-</b>			

		1	For State Registrar	State of Mar	ryland		rtment of F		ind Mer		iene g. No.2 0	06	35691
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Exa Fune	mine		5. Social Security Number 6.5	ENCTON WE		t Gr st birthday)	4b. City, Town, of If Under 1 Year Months Days	_	UENI	Date of Birth (Month, Day,		2 AE	place (State or Foreign
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th wit		<u>a</u>	1307 Biddle Court	3			21228				USA		
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nding Physath.		ation: 10	1 ☐ Yes 2 Д No  27. Manner of Death 1 ☑ Naturat 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day)		WOutpatient 8b. Time of Injury	28c. Injur Wor		28d		nce 6 □Oth w injury occur		1)
tal or Atterns et et dear dear	n for most	Certification	3 ☐ Suicide 6 ☐ Could not be determined		y - At hom (Specify)	e, farm, stre	et, factory, office		28f.	Location (Str City or Town,		er or Rura	l Route Number,
To the Hospital or Attending Phyminin 24 hours effer death. To the Funerate Director: Affect this companies in the things.	inpletery in	edical	one) 2 Medical Exa	nysician: To the best of miner: On the basis of e and manner state	xaminatio	edge, death in and/or inv	occurred at the tir estigation, in my d	ne, date and opinion, deat	d place, and h occurred a	due to the ca at the time, da	use(s) and ma ite and place,	inner as st and due to	ated. the cause(s)
5.4 <u>₹</u> 5.5	3		29b. Signature and title of certifier	- Can-		Mi	29c. Licens	redmun es		29	o. Date signe الم	J (Month,	Uay, Year)
4			30 Name and address of person who		ith (Item 2	(3a) (Type, I	Print)	11-011	Bur	MA	wa.	20	Day, Year)  9 2006
Reç	Stat gistra	9	31. Date filed (Month, Day, Year) NOV 1 3 2	006 32 Registrar	Signatu	2	and of	1			)		

			1 - For Stata Registrar	State of Maryl			of Health and of Death	-	giene 200	6 35692
	Dhusisi		1. Decedent's Name (First, Middle, Las	t)				2. Date of De		3. Time of Death
	Physici /Media		Joseph Korneluk						6/06	9:00 a.th.
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Tov	wn, or Location of De	ath	4c. County of	Death
			1830 Norfolk Roa				Glen Burni		Anne A	
	Funeral Director		215-04-1/45	7. Age (In )	Yrs. last birthday)	If Under 1 Y Months D	ear If Under 24 H ays Hours Mi		9. 19, Year) 168	Birthplace (State or Foreign Country) Maryland
	and		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Marylan f show	ō	MTD Z Z	9 - 9	<b>61</b> 5					1 ☐ Yes 21X No
	the 28s	rec	MD Anne Art 10e. Street and Number	maer	Glen B	10f. Zip Co	de		10g. Citizen of Wha	at Country?
	3a o	Ö	1830 Norfolk Roa	o.d		210	161			ŕ
	deetl	Funeral Director	11. Marital Status	12. Was Decedent Ever in	n U.S. 13.		of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No	USA 14. Race -	American Indian,
9	after or Ite	F	Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 25 No	1	1 Tes, specify		erto Hican, etc.)		White, etc. White
8	72 hours after deeth with the Maryland naturel', or items 23a or 28e-f show iloal Examinar must be notified at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 1 1 1 6 S Z E	No Specify:		Specify:	WILLCE
5	72 h natu	ete	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	dent's Usual O kind of work d	lone during most of w	vorking	16b. Kind of Busin	ess/industry
21215-0036	within lene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use re			T 7	
2	Hygi ther of		17. Father's Name (First, Middle, Last)			Seli-	-employed	ame /First Middle	Lands	caping
au	Mental I	Be c	Larry Korne	al rale						
7	2 should and Men is marke	ဥ	19a. Informant's Name/Relationship (7		19b Maili	na Address /St		Lee Brid	ggeman ør, City or Town, Sta	ite. Zin Code)
Maryland	2 2 2 2		Larry Korneluk/Fa						ie, MD 210	
6	1 a 1 a 1		20a. Method of Disposition		b. Place of Dispo	sition (Name o	of !	Date	20c. Location - Cit	
e E	00		1   Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	cemetery, crei adownidae		l Park 111/	08/06	Elkridge	e. MD
Baltimore,	_ 든 본 글		21. Signature of Funeral endice Licen		22	2. Name and A	ddress of Facility			
ä	Depa Impo eny it		Melle		G	ary L.	Kaufman F	uneral Ho	ome @ MMP	Inc.
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the d	eath. Do not ent	er the mode of	shington E dying, such as card	ac or respiratory a	rrest.	21075 Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	To s	- ficul	1 -	ancer			Onset and Death
1	/Medical		resulting in death)	Due to (or as a cons		47- C	ancer		·	2291
	Examiner		Sacrentiativ list conditions	b						
	P #	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	sequence of):					
	and -trans	Саш	Cause (Disease or injury that initiated events resulting in death) Last	C. Dun to (or on a seri						
68760,	death certificate be executed e attending physicien and of for use as the burial-transit	cal E		Due to (or as a cons	sequence or):					
282	physicate sthe			d.						
×	eath certific attending p	Physician/Med	IF FEMALE:	23c. If yes, outcome of pre	gnancy			- N. A.	22d Pate of	(deline)
Вох	atter for u	ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ P 4 ☐ Pregnant at time of	etal death 3	Ectopic pregn Other (specifi			23d. Date of Month	Day Year
P.O.	t the de by the	hysi	1 Yes 2 No 9 Unknown	9□ Unknown						
	The law requires that the ate hes been signed by th bage 2 should be detache	by P	Part II. Other significant conditions co	ontributing to death but not	resulting in the u	nderlying cause	e given in Part I.	23e. Did t	obacco use contribu	te to the cause of death?
Vital Records,	w require been sig should b	pa						10	Yes 2 No 3[	Probably 4 Unknown
သို့	aw requis been 2 should	plet						24a. Was		e autopsy findings available
æ	The lav	Completed						autor perfo	rmed? deat	to completion of cause of h? Yes 2DNo
ita	ician: Th certificate ector, pag	Bec	25. Was case referred to medical examiner?				26. Place of D	eath (Check only o		163 22 (10
o	S 0 5	2	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2	ER/Outpatier	nt 3□ DOA	Other: 4 Nursing	Home 5 Resid	dence 6 Other (	Specify)
n O	D 0 0		27. Manner of Death 1    Natural 5 □ Pending	28a. Date of Injury (Month, Day Year	28b. Time o		Injury at Work?	28d. Describe	how injury occurred	
sio	tendi eath. or; A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be			М	1 ☐ Yes 2 ☐ No			
Division	or Attending after death. Director; After in by the fune	Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecify)	eet, factory, off	fice	28f. Location (S City or Tox	Street and Number o wn, State)	r Rural Route Number,
	Hospital		CO. C. Alice							
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director; After completely filled in by the fun	Medical	29a. Certifier (Check only one)  2 Madical Exam	/sician: To the best of my liner: On the basis of exam and manner stated.	knowledge, deatl ination and/or in	h occurred at th vestigation, in r	ne time, date and pla my opinion, death oc	ce, and due to the curred at the time,	cause(s) and manne date and place, and	or as stated. due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	and marrier stated.		29c. Lic	cense number		29d. Date signed (N	fonth, Day, Year)
	- S + ō		1//	1/1/2-	//		D310	ا (ے	Novo-L	0.1.25-1
1	0		N me and address of person who d	olio and suse of death (I	tem 23a) (Type,	Print)	1 1	J /	10000 100	1 6,000
6	)	9	X450/12.02/	un 305-	400	si tal	Drive	· F/ei	Burnie.	er 6,2006 M. 406/
	Sta		31. Date filed (Month, Day, Year)	32. Flegistrar's Si	gnature	DEALL P		) -/	7	<u> </u>
0	Registr	ar	NOV 1 3 20	106 MAGAS	15 60	LIE THE STATE OF				

karneluk

Joseph

	Sta Registr		31. Date filed (Month, Day, Year)  NOV 1 3	32. Polistrar's Signatu	23a) (Type, Print)  AAM (  Jre  Line	-		
	10		30. Name and address of person we Stephen	the completed cause of death (Item :				, , , , , ,
	TW T		Leish	Clar MD		D58510		11/06/06
	To the Hosi within 24 ho To the Func completely f	Medical	(Check only 2 Medical E	xaminer: On the basis of examination and manner stated.	on and/or investigation, in	n my opinion, death occuri	red at the time, date a	and place, and due to the cause(s)  Date signed (Month, Day, Year)
ב	urs ere		29a. Certifier 12 Certifying	Physician: To the best of my know	riedge, death occurred at	the time, date and place,	and due to the cause	n(s) and manner as stated
Division	ol or Attendi after death. I Director: A d in by the fu	Certification	2 Accident investigation   3 Suicide 6 Could not determine   4 Homicide	ot be	me, farm, street, factory, o	1 Yes 2 No	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
on of	ttending Phydeath. tor: After thi	tion: T	27. Manner of Death 1. Natural 5 Pending	28a. Date of Injury (Month, Day Year)		c. Injury at Work?	28d. Describe how in	
r Vital	Physicien: this certific ral director,	Fo Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	R/Outpatient 3 ☐ DOA	Other	h (Check only one) me 5 Residence	6 ☐Other (Specify)
			OF Manager of the second				autopsy performed 1 Yes 2	prior to completion of cause of death?  No 1 Yes 2 No
Hecords,	law requise been second	Completed					24a. Was an	2 No 3 Probably 4 Unknown  24b. Were autopsy findings available
<u>ર્</u>	w requires that is been signed by should be deta	by	Part II. Other significant condition	ns contributing to death but not result	ting in the underlying cau	ise given in Part I.		o use contribute to the cause of death?
O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dear 9 ☐ Unknown	death 3 Ectopic preg			23d. Date of delivery  Month Day Year
	certificat Iding phy Ise as th		IF FEMALE:	23c. If yes, outcome of pregnan	icy			22d Data at delicary
68/60,	icate be executed physician and s the burial-transit	edicai Ex	resulting in death) Last	Due to (or as a conseque	ence of);			
	ocuted nd iransit	Examiner	Sequentially list conditions, if any, leading to immediate caus s. Enter or defining Cause (Disease or injury that initiated events	Due to (or as a conseque				
	Examiner	Ļ	Sequentially list conditions,	, communit	4 acqui	red pap	umonio	
,	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Septicem  Due to (or as a conseque	, a.			Onset and Death
	005 e d		23a. Part I. Enter the disease, or shock, or heart failure. List o	amplications that caused the death.		2601 Mountain Ro	ad - Pasadena, M	
Baltimore,	permit. Pag Department Important: I any injury c		4 □ Donation 5 □ Other (So 21. Signatur → □ ne √ i Service □	ecity)		ERISTEY II - 9 Address of Pacility  Jigherty Family Funera	Home And Crema	ation Center, P.A.
Jore,	of Ho	1	20a. Method of Disposition 1 □ Burial 2 ☑ Cremation	3 □Removal from State A CO	ace of Disposition (Name metery, crematory or othe	of er place)	Date 20c.	Location - City or Town, State
Mar	d 2 7 Is		19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Mailing Address (S	Street and Number or Aur	al Route Number, Cit	y or Town, State, Zip Code)
yland	should be fill and Mental H. B. marked oth	To Be	17. Father's Name (First, Middle, L GEORGE M			18. Mother's Nam	e (First, Middle, Maid LNASI	den Sumame)
717	filed within 72 Hygiene. ther than "na ant, Ine Mudic	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	PLUMBI	ER	PZ	LUMBING CO-
15-0036	표 그	leted	15. Decedent's (Specify only highest	s Education	16a. Decedent's Usual (Give kind of work	Occupation done during most of work retired)	ing 16b.	Kind of Business/Industry
20	or ite	by Fun	1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Forces?	If Yes, specify	nt of Hispanic Origin? (Sp y Cuban, Mexican, Puerto No Specify:	Rican, etc.)	Black, White, etc.  Specify:
	death wit	erai D	4921 CHESTAL  11. Marital Status	12. Was Decedent Ever in U.S		LO764	ecify Yes or No-	U 5 A
	with the Ma a or 28e-f s t be notifie	Funeral Director	10e. Street and Number	Arundel 3	10f. Zip C		10g.	1 Yes 2 No  Citizen of What Country?
	Maryland -f show fled at	_	Usuel Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location .			10d. Inside City Limits
ľ	Funeral Director		571-64-3218	6. Sex 1 1 2	Yrs. If Under 1  Months I	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Yea	ar) 9. Birthplace (State or Foreign Country) WASHINGTON D.C.
	Examin	er		MEDICAL CENTE	R ANA	own, or Location of Death	A	4c. County of Death  WERUNDEL
	Physicia /Medic		GEORGEMEL	VIN KELL			NOV. 6	2006 22:14 M
			For State Registrar  1. Decedent's Name (First, Middle,	· · · · · · · · · · · · · · · · · · ·	Certificate		Reg. I	2000 0000
			_ For	State of Maryland	Department	of Health and IV	rientai Hygier	19 006 25603

			1 - For State Registrar	State of M	aryland				ealth ar D <i>eath</i>	nd Mei		ene 2006	35694
	Physici	an	1. Decedent's Name (First, Middle, Last, Marca Crack		L V P	csh	010				Date of Death Month	Day Ye.	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	)		4b. City,		Location of	Death	octobe	4c. County of D	:26
	Funeral Director		5. Social Security Number 6. Se		ge (In yrs. Ias 82	t birthday) Yrs.	If Under Months	1 Year Days		Min.	Date of Birth (Month, Day, uly 12	Year) 9.	Birthplace (State or Foreign Country)
	e Maryland	ctor	10a. State 10b. County MD Baltimor	:e	10c. City,	Town or Lo		1					10d. Inside City Limits 1 Tyes 2 No
	with th	Dire	10e. Street and Number	D 1			10f. Zip				10	g. Citizen of What	Country?
900	ges 1 end 2 should be filed within 72 hours after deeth with the Maryland to Health and Mentat Hyglene. If item 27 is marked other than "natural", or iteme 23a or 28a-f show or other traumatic event, the Medical Exeminar must be notified at	d by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Decedent Armed Forces' 1  Yes 2 X If Yes, Give Year or Dates:	?		Was Deced f Yes, spec	dent of Hi cify Cuba		in? (Specify Puerto Ric	y Yes or No- an, etc.)		umerican Indian. Unite, etc. nite
1215-	within 72 h ene. than "nate	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 1 2			16a. Dece (Give life	kind of wo DO NOT us	al Occupa rk done d se retired	ation <i>luring</i> most o )	of working	1	6b. Kind of Busine	
מ טר	other vent,	Be C	17. Father's Name (First, Middle, Last)			HOL	I.		18. Mother's	s Name (F	irst, Middle, M	laiden Sumame)	.re
ylaı	Menta Menta Marked	ToE	Clearance Willis								e Fout		
Baltimore, Maryland 21215-0036	permit. Pages 1 end 2 sh Department of Health and Important: If Item 27 Is n any injury or other traum		19a. Informant's Name/Relationship (T)  Lois Johnson/daug  20a. Method of Disposition  1 □ Burial 2 □ Cramation 3 □ F  4 ☒ Donation 5 □ Other (Specify)	hter	com		St.	Paul	Stree		npstead	City or Town, State  MD 21  Oc. Location - City	074
Balti	permit. P Departm importer any inju		21. Signatur of Fineral Sprice Licens		gerge	S <sup>2</sup> t	ate A	Mate ore,	ony Bo MD 2	ard 6 1201	55 W.	Baltimore	Street
8760,	Physician /Medical bubbicion and physician and physician and physician and physician it is physician and physician	dical Examiner	23a. Part1. Enter the disease, of comp shock, or leart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as	line.	nce of):							Interval Between Onset and Death
P.O. Box 68	ath certif	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal de	eath 3	Ectopic pr Other (sp					23d. Date of Month	delivery Day Year
rds, P	w requires that the de been signed by the e should be detached f	by	Part II. Other significant conditions co					•			23e. Did tob		e to the cause of death?  Probably 4 (Obnknown
Division of Vital Records,		Completed	Hypertension							_ [	24a. Was an autopsy perform	prior	
Vita	Physicien: Th r this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			heck only one		
on of	ing Afte une	tlon: To	1 Yes 2 No  27 Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, Da	ury 2	VOutpatier 8b. Time o Injury		8c. Injury Work	at	28d		nce 6 Other (S	Specify)
Divis	et Circ	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	njury - At hometc. (Specify)	e, farm, str	eet, factory	, office		28f.	Location (Str. City or Town,	eet and Number or State)	Rural Route Number,
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Lertifying Phyone) 2 Medical Exami	rsician: To the best iner: On the basis of and manner s	ot examination	edge, deat n and/or in	occurred vestigation	at the tim , in my op	e, date and printed	place, and occurred a	due to the car at the time, da	use(s) and manner te and place, and d	r as stated. due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	0 2 1				. License		27		d. Date signed (M	
	e a ≅ Sta		30. Name and address of person who co Karen L. Babi +  31. Date filed (Month, Day, Year)	ompleted cause of	death (Item 2	3a) (Type,	Print)				-		MD 21136
	Regist	rar :	NOV 1 3 2006	El gue	AT. X	14794	الورية						

			1 - For State Registrar	Sta			nd / Depa		t of H	ealth a		lental Hyg		2006		35695	
			1. Decedent's Name (First, Middle	, Last)								2. Date of Dea	th			3. Time of Death	_
}	Physici /Medic Examir	al	Wavie Light 4a. Facility Name (If not institution	, give street	and number,	)		4b. City,	Town, or	Location of	of Death	Month 11/11,		County of De	8	:03 a.m.	_
			Casey House					Roo	ckvil	le			Mo	ntgome	rv		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 3			last birthday)	If Under Months	1 Year	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day		9. E	irthplac	e (State or Foreign	
	Director		214-10-4893 Usual Residence of Decedent	1	EV.	87	Yrs.					4/10/19	19	- 1	VA	,	_
	land bw	-	10a. State 10b. County			10c. Ci	ty, Town or Lo	cation	-				-		10d	. Inside City Limits	
	Mary	ğ	MD Prince	Georg	es		Lanham	1								1 ☐ Yes 2 🙀 No	
	r 28e	Director	10e. Street and Number	0001	,00	1	Dailian	10f. Zip	Code				0g. Citi	zen of What	Country	?	-
	h witi	0	9116 7th Street						20706	;			U	ISA			
	deal	ner	11. Marital Status	12. Wa	s Decedent	Ever in U	J.S. 13. \				gin? (Spe	cify Yes or No- Rican, etc.)		14. Race - Ar Black, Wi			_
36	or it	by Funeral	1 Never Married 2 Marri	ed 1 [	Yes 2⊠ ′es, Give	No		Yes			, , , ,	110011, 010.)					
ö	ure!	d b	3 ☑ Widowed 4 ☐ Divorced		ar or Dates:										Whi		_
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or Items 23a or 28e-1 ehow the Madical Examinar must be notified at	Completed	15. Decedent (Specify only highes	t grade comp			16a. Deced	lent's Usu: kind of wo DO NOT u:	rk done d	urina most	t of worki	ng	16b. Kir	nd of Busines	ss/Indus	stry	
72	iene.	ошь	Elementary/Secondary (0-12)	Co	llege (1-4or	5+)			nemak				0	wn Hom	e		
ַ	Hyg othe	Bec	17. Father's Name (First, Middle,	Last)			.1				r's Name	(First, Middle,					-
<u>a</u>	Aenta Aenta rked tlc e	To B	James Elliott	Thom	son						Nano	cy Emma	Co1	е			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 ie marked other than "neturel", or Items 23a or 28e-1 ehow other traumatic event, the Medical Examinar must be notified at	. 3	19a. Informant's Name/Relations	nip <i>(Type, Pr</i>	int)		19b. Mailin	g Address	(Street a	nd Numbe	r or Rura	l Route Number	City of	r Town, State	, Zip Co	ode)	_
	1 and 2 Health tem 27		Patricia Hargr	ove/da	ughte					Ct.	, Elc	dersburg	J, M	D 2178	4		
Baltimore,	Fiter of H		20a. Method of Disposition  1X☐ Burial 2 ☐ Cremation	3 □Remova	I from State		Place of Dispo cemetery, cren	sition (Nar natory or o	ne of ther place	9)	D	ate	20c. Lo	cation - City	or Town	, State	
Ë	permit. Pages Department of I Important: If its eny injury or of		4 ☐ Donation 5 ☐ Other (Sp	oecify)			dowridae	Memor	rial F	ark	11/2	L5/06	Elk	ridje,	Ma	ryland	
3a	Deparition of the popular in the pop		21. Signature of Funeral Service I	icensee						s of Facility		Home@M	ND T	m			
	40 = 0 0		220 Don't Sounds divers		45-4			50 Was	himt	an Bla	rl $-$ F	Ikriche	MD.2	1075			_
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a		e Cer	rebrova								In	oproximate terval Between nset and Death	_
760,	te be executed ysician and ie burial-transit	cal Examiner	Sacuentally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Oue to (or as												
.O. Box 68	Attending Physician: The law requires that the death certificate be executed refath.  r death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Media	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	10	es, outcome ]Live birth ]Pregnant a ]Unknown	2 Feta	Il death 3 🗌	Ectopic pr Other (sp					2	23d. Date of d Month	elivery Da	ıy Year	
Records, P	quires that n signed t uld be det		Part II. Other significant condition	ns contribution	ng to death b	out not res	ulting in the ur	iderlying c	ause give	n in Part I.			acco us			cause of death?	
000	s bee	Completed										24a. Was a	n	24b. Were	autopsy	findings available	-
Ä	nysician: The law his certificate has t i director, page 2 s	E										autops perfor	ned?	death?	comples 2[	etion of cause of	
ita	ian: rtifica ctor, p	Bec	25. Was case referred to medical examiner?					- 3		26. Place	of Death	Check only on	(M) No	1016	13 ZL		-
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	16		30. Name and address of person v													20855	
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			1. Decedent's Name (First, Middle, Last)					2. Date of De	ath	V	3. Time of	f Death
	Physici /Medic		Choung So	ook Lee				Novemb	er <sup>Day</sup> ,	20ŎĞ	4:00	Рм
1	Examin		4a. Facility Name (If not institution, give	street and number)			, or Location of Dea	ath		ounty of Deati		
	MI.		18665 Sandpiper	Lane		1.	nersburg			Montgor		
lega,	Funeral Director		5. Social Security Number 6. Sec. 1	7. Age (In yi	s. last birthday) Yrs.	If Under 1 Year Months Day			th ly, Year)	9. Birtl Co	nplace (State d untry) th Kore	
(20)	ס		Usual Residence of Decedent					Jalle 4	, 175	J   500	CII NOLE	:a
	show	بد	10a. State 10b. County		City, Town or Lo		1.0				10d. Inside C	•
	8a-f	Director	Maryland Montgom	ery		Gaithe						2 <b>∑</b> No
	with t	Ē	10c. Street and Number			10f. Zip Code	) 08 <b>7</b> 9		-	en of What Co ited Si		
	eath must	era	18665 Sandpiper L	ane 12. Was Decedent Ever in	[] \$ 13			(Specify Ves or No		I. Race - Ame		
36	2 should be filed within 72 hours after death with the Maryland and Menial Hygiene. In marked other than "natural", or Items 23s or 28s-f show sumatic event, the Madical Examinat must be notified at	by Funeral	1 □ Never Married 2 □ Married  3 🏝 Widowed 4 □ Divorced	Amed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Co	If Hispanic Origin? ( uban, Mexican, Pue lo Specify:	erto Rican, etc.)		Black, White		an
Ş	2 hours	edt	15. Decedent's Edu		16a. Dece	dent's Usual Occ	cupation		16b. Kind	of Business/I		ALI
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<u>₹</u>	should and Men marke umatic	2	Nak-Hee Lee					lyang Kwa				
Maryland 21215-0036			19a. Informant's Name/Relationship (Ty. Kevin Kim/Son	pe, Print)			et and Number or F				·	70
	1 and Health 16m 27		20a. Method of Disposition	206		S HALL GE esition (Name of matory or other p	escent Dr	Date		ation - City or		179
o D	Pages ent of int: If It		1 ☐ Burial 2 【Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval nom State			121041	ember 13,				. 1
Baltimore,	ertme ortan Injur		21. Signature of Funeral Service License		nteamery	Crematori  Name and Add	m Z fress of Facility	.006	Beth	esda, l	Marylar	<u>na</u>
ñ	permit. Depertr Importe any Inje		Ky Inc	MOO	198 Ro	bert A.	Pumphrey	funeral	Home	/Rockv	ille, 1	nc.
237			23a. Part1. Either the disease, or complishock, or heart failure. List only or	cations that caused the de		er the mode of d	onteomery ying, such as cards	ac or respiratory a	rrest,	TE, 1110	Approximal Interval Bet	le hween
	Physician		Immediate Cause (Final disease or condition	Sepsis						ş ·	Onset and	Death
	/Medical		resulting in death)	Due to (or as a cons	equence of):						3 days	
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200	sit ed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):							
_	and and Il-tran	хап	that initiated events resulting in death) Last	Due to (or as a cons	equence of):							
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28	ificate g phy: as the	edic										
ROX	eath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		75,000,000			23	d. Date of deli	very	
	death	sicia	in the past 12 months? 1 ☐ Yes 2 🎛 No	4 Pregnant at time of		Ectopic pregnar Other (specify)				Month	Day	Year
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Ö	w requ been shouk	ete						24a. Was	20	24b. Were au	oney findings	available
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ta	ician: T certificet rector, pa	0	25. Was case referred to medical				26 Place of De	1 ☐ Yes eath (Check only o	2 No	1 L Yes	2 🗆 No	
<u>=</u>	Physician: this certifice al director, I	To B	examiner? 1 X Yes 2 □ No	lospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3□ DOA	)there	Home 5 ₩ Resi		Other (Spec	ifv)	
0	ding Ph h. After th funeral		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	28c. ln		28d. Describe			.,,,	
<u> </u>	Attendir death. ctor: Af y the fu	atic	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	,,	,,		□Yes 2□No					
Division of	or A	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, str cify)	eet, factory, offic	е	28f. Location ( City or To	Street and wn, State)	Number or Ru	ra / Route Num	iber,
	To the Hospital within 24 hours a To the Funeral completely filled		29a. Certifier 1 X Certifying Phys	icien: To the best of my k	nowledge, deat	n occurred at the	time, date and place	ce, and due to the	cause(s) a	nd manner as	stated.	
	he Hc n 24 l he Fu oleteky	Medical	(Check only 2 Medical Examination)	ner: On the basis of exami and manner stated.	nation and/or in	vestigation, in my	y opinion, death occ	curred at the time,	date and p	lace, and due	to the cause(s	;)
	withi To ti	Σ	29b. Signature and title of certifier			29c. Lice	nse number		29d. Date	signed (Month	, Day, Year)	
)	4		12	cer	$\supset$		D0021033	3	Novem	iber 11	, 2006	
10	2		30. Name and address of person who co			•			2			
1			Byoung K. Lee, M.D. 31. Date filed (Month, Day, Year)				ilver Spr	ing, Mar	yLand	1 2090	6	
*	Sta Registr		NOV 1 9 200	32 Registrar's Sig	M. A.	acti I						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Laura W. Long 11:15 AM 01 2006 NOVEMBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 987 Via Amorosa Arnold Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 21 F 400-20-4972 94 Director May 11, 1912 New York Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location worde 10d. Inside City Limits rthen "natural", or Items 23s or 28s-f ehov tre Medical Examiner must be notified at 1 Yes 2 No Anne Arundel Arnold Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 987 Via Amorosa 21012 **USA** death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amed Forces? 11 Marital Status 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎗 No Specify: 2 Specify: white 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Whitis Fannie Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . nt of Health a Angela Petrunicio/daughter 987 Via Amorosa Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If ite
eny injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade, 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street enn Paltimore, MD 21201

23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot or heart failure. Lift only one cause on each line. Approximate Interval Between Onset and Death Immediate use (Final disease or condition resulting in death) Physician a LORONARY ARTERY DISFASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions. If any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (u. as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PAIN SYNDROME 1 ☐ Yes 2 XNo 3 Probably 4 Unknown Completed DEGENERATIVE JOINT DISEASE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed CHRONIC OBSTRUCTIVE PLILMONARY DISEASE 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury al Work? Certification: 28d. Describe how injury occurred Injury Natural 5 Pending 1 TYes 2 No 2 Accident investigation Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel [ Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month Day Year) D57531 NOVEMBER 01, 2006 Malnego MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Veterans Huy Jule 204 Millersville MD 21108 31. Date filed (Month, Day)Year) 8601 3 Registrar's Signature State NOV 1 3 2006 Registrar

06-08370 William Lvnch

Please Type or Print in Black Indelible Ink
State of Marvland / Department of Health and Mental Hygiene

Villiam Lynch	- 1	- For State Registrar	e of Maryland / I	-	cate of Death			eg. No. 200	6 3569
Physiciar Medical Examin	-	Decedent's Name (First, Middle,L	ast)		·	_	2. Date of Deat Month November		3. Time of Death 1930 hrs
Weulcai Examini		William Lynch 4a. Facility Name (if not institution, g	ive street and number)		4b. City. To	wn, or Location of D		4, 2006 4c. County of Dear	
k.		10 West Fort Avenue	,		Baltim				_
Funeral	T			In yrs. last b	irthday) If Under Months	1 Year If Under 2 Days Hours	Min	th(MM/DD/YYYY) 9. B Fore	irthplace (State or
Director	L		Хм 2 F	65	Yrs.	Days Hours	Sept 1	.9, 1941	ountryMaryland
any	ŀ	Usual Residence of Decedent  10a. State 10b. County	10	c. City, Tow	n or Location	<del>-</del>	-		10d. Inside City Limits
	إ	MD		Ва	ltimore				1 X Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number			10f. Zip (		10	0g. Citizen of What Co	untry?
th the	٥	10 W. Fort Aven				21230		USA	
more, MD 21215-0036 Pages I and 2 should be flied within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoor other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Marri	12. Was Decedent Ev	ver in U.S.		t of Hispanic Origin? Cuban, Mexican, Pu	? ( Specify Yes or No- uerto Rican, etc.)	14. Race - Ame White, etc.	rican Indian, Black,
ifter de	진	3 Widowed 4 X Divorce	1 Yes 2 A ed If Yes, Give Year or Dates:	No	1 Yes 2	No specify:		Specify: whi	te
hours a	ed b	15. Decedent's Education (Specify	only highest grade compl	_	a. Decedent's Usual C			16b. Kind of Business	/Industry
36 iin 72 than "	흷	Elementary/Secondary (0-12)	College (1-4 or 5+)	'	paint	-	<b>-</b> ,	self emp	loved
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than cevent, the Medica	Completed	17. Father's Name (First, Middle, La			parm		Name (First, Middle, M	1	Toyeu
1215   be fill   be fill   be fill   rked   vent, 1	Be	George Lynch					earl Brook		
D 2121 Should be f and Mental 7 is marked	의	19a. Informant's Name/Relationship		- 1				nber, City or Town, Stat	
and 2 sho are 2 sho fealth and tem 27 is traumati	1	Karen Foster/da 20a. Method of Disposition	ugnter		e of Disposition (Name		Date Drive E	1kridge, M	
nore ages 1 at: If i		1 Burial 2 Cremation		crem	atory or other place)				
Baltimore, ME permit Pages I and 2 a Department of Health a Important: If item 27 injury or other traum	-	Donation 5 X Other Special Constitute of Funeral Service Lice Ropa 1 d S	ensee Wald, Bire	tor	22. Name and A	ddress of Facility	ard 655 W	Baltimore	Street
	4	1m1/1	VX UUL		Raltimo:	e. MD 21	1201		
Physician /Medical	-	2 Part I. Enter the dis se, / contiller. List only se cause on				dying, such as card	liac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
Examiner	-	Immediate Cause (Final disease or condition resulting in death)	Atherosclerotic Co		cular Disease				Deatri
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760, cate be physici	ş	IF FEMALE:	23c. If yes, outcome	of pregnance	у			23d. Date of delive	ry
68 certifi	jan	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at tin	ne of death	Fetal death  Other (Speci	3 Ectopic pr	regnancy	Month	Day Year
Box 687 e death certific the attending p	Physician/	1 Yes 2 No 9 Unkno	wn 9 Unknown		5 Other (Speci	<b>y</b> /			
that the red by detach	by P	Part II. Other significant condition	s contributing to death b	ut not result	ing in the underlying o	ause given in Part I		obacco use contribute to	
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Vita ysiciar his cer	mĭ	examiner?	Hospital: 1 Inpatient	2 ER/	Outpatient 3 DC	Other	-	Residence 6 V Other	er: Scene
of ing Ph	일	27. Manner of Death	28a. Date of Injury (Month, Day, Year	28t	o. Time of Injury 28	c. Injury at Work?	28d. Describe r	now injury occurred	
Sion vittend death. ctor:	읋	1 Natural 5 Pending 2 Accident Investig	ation			1Yes 2No			
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Hospit 24 hour Funeriely fill		29a Certifier	ician: To the best of my k	nowledge, d	eath occurred at the t	me, date and place,	, and due to the caus	e(s) and manner as sta	rted.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	,	er: On the basis of examinand manner stated.	_				, ,	
	Σ	29b. Signature and title of certifier	0			License number		29d. Date signed (Mo	
	ļ	Jusho - 2	THO			O.C.M.E.		November 5, 20	
		<ol><li>Name and address of person what Tasha Greenberg MD.</li></ol>	o completed cause of dea Assistant Medical		,	eet, Baltimore,	, MD 21201		
Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	1. 11 -				
Registr	ar	NOV 1 3 200	10 Magine 1	45	CARRIEL !				

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snawritrice Moore	R	For State		t Maryland /	•	ificate of		iu ivieritari		eg. No. 200	6 35699	
Physician/ Medical Examine		Decedent's Name (First, SHAWNT		MARIE MO	ORE				Date of Dear     Month     November		3. Time of Death 1445 hrs	
	4	la Facility Name (if not in: Bon Secours Hos	· -	street and number)		4	o. City, Town, o	r Location of Dea		4c. County of Deat	h	
Funeral Director	Н	Social Security Number	6. Sex		(In yrs. las	t birthday)	If Under 1 Ye		Min.	th(MM/DD/YYYY) 9. Bi Forei	rthplace (State or gn gn MARYLAND	
Director	_	219-82-6703 Jsual Residence of Deced		1 2X F	37	Yrs.			09/0	1/1969 0	oun#y)AKIDAND	
ow any		Oa. State 10b. Co	ounty N/A			own or Location	RE CIT	·γ			10d. Inside City Limits  1 X Yes 2 No	
the Maryland a or 28a-f sh tified at once	<u> </u>	0e. Street and Number					10f. Zip Code		1	0g. Citizen of What Cou	untry?	
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5-0036 ed within 72 hour lygiene other than "natu the Medical Exan	אנבונ	Elementary/Secondary	0-12)	College (1-4 or 5	+)	-	SABLED	e. DO NOT use r	etired)	DISABI	,ED	
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, MD and 2 sho ealth and em 27 is raumati	L	ASHLEY GR		/ DAUGE			PERSI		R, REIS	TERSTOWN,	MD 21136	
Baltimore, permit. Pages I ar Department of He Important: If ite	- 1	1 X Burial 2 Cre 4 Donation 5 Ot	_	Removal from Sta	le	ematory or oth NG ME	erplace) M PARK	1	1/15/06	WINDSOF	R MILL, MD	
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director		21. Signature of Funeral Service License 22. Name and Address of Facility HOWELL FUNERAL HOW 4600 LIBERTY HEIGHTS AV, BALTIM										
Physician	hysician    243 Part I. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Approximate the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Description										Approximate Interval Between Onset and	
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Box 687 e death certific the attending p ed for use as th		3b. Was decedent pregna past 12 months?		1 Live birth 4 Pregnant at	time of deat	- H	al death 3 er (Specify)	Ectopic preg	gnancy	Month	Day Year	
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al Re an: The errificate stor, page	ו ע	25. Was case referred to r	nedical				26.Pla	ce of Death (Che	1 Yes	2 No 1 Y	es 2 No	
of Vita Physicia ter this ce eral direc	≥├	examiner?  1  Yes 2 N 27. Manner of Death		28a. Date of Inju (Month, Day,Y		R/Outpatient 28b. Time of Ir		Other Nur	sing Home 5	Residence 6 Other	er:	
ttending teath ttor: Af	ation	1 Natural 5 Accident	Pending Investigation		ear)		1	Yes 2 No				
Division ospital or Attending to the spital or Attending to the death of the spital of		3 Suicide 6 Homicide	Could not be determined	28e. Place of In (Specify)	ury - At hor	ne, farm, stree	t, factory, office	building, etc.	28f. Location (S or Town, S		ural Route Number, City	
		29a Certifier 1 Certification								se(s) and manner as sta and place, and due to t		
To t	Medical	29b. Sygha(ure and title of		and manner stated				nse number		29d Date signed (Mo		
	1	MA	4	10	4h /!!	20-1	0.0	.M.E.		November 6, 20	06	
3		30. Name and address of Susan Hogan MI		ampleted cause of d tant Medical Ex			n Street, Ba	ltimore, MD	21201			
Stat Registra	V.	31. Date filed (Month, Day		32. Registra	r's Signature		afa)					

		•	For State Registrar	State of Ma	ryland /		artment of H rtificate of L		and Mei		iene (	006	3570	0
	Physicia	20	Decedent's Name (First, Middle, La						2.	Date of Deat	h Day	Year	3. Time of Dea	
	/Medic	al	Otephen Au  4a. Facility Name (If not institution, giv		thers	<b>&gt;</b>	4b. City, Town, or	Location		ovember		2006 ounty of Death		М
	Examin	er	Baltimore V	A Medical	Contr	r	Bal	timo			40.00	unty of Death		
	Funeral Director		5. Social Security Number 6. S		(In yrs. last bi		If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. 8.	Date of Birth (Month, Pay, UNE 1,	1949	9. Birth Cou Mary	nplace (State or Foi intry) Land	eign
	and w		Usual Residence of Decedent  10a, State 10b, County		10c. City, Tov	vn or Lo	cation	<del></del>					10d. Inside City Li	mits
	Mary I sho	tor	Maryland Howard		Elkr	idg	е						1 ☐ Yes 2 💆	No
	or 288	Oirec	10e. Street and Number				10f. Zip Code			10	-	n of What Cou	•	
	s 23a	rai	7875 Butterfiel		i= II C	10.		075	nin 2 / Cn no 14	. Van ar Na		U.S.A.		
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exertinate by notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ∑Yes 2 ☐ N If Yes, Give Year or Dates:			Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2XNo	Specify:	gin / (Specir i, Puerto Ric	y res or No- an, etc.)		Black, White		
21215-0036	72 hor	Completed	15. Decedent's E (Specify only highest gr		168	(Give	dent's Usual Occupa	durina most	t of working		16b. Kind	of Business/l	ndustry	
121	within ne.	mple	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	DO NOT use retired	1)	· ·		C	'tool		
9	filed v Hygie other i	e Co	12 17. Father's Name (First, Middle, Las.	")			ntractor	18. Mothe	r's Name (F	First, Middle, N		teel mame)		
ılan	uld be Aental rked o	To Be	Charles Mitche	ll Mathers	, Sr.			El	eanor.	Virgin	nia A	ustin		
Maryland	2 sho and h is ma		19a. Informant's Name/Relationship				ng Address (Street							
e, P	1 and Health Bm 27 thar t		Stephen Abbuhl ( 20a. Method of Disposition	Brother-n-			1 Argo Dr	ive	Dayton			L 21036 tion - City or T		
Baltimore,	Pages tment of i tant: If Its		1 ☑ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Special Control of Con	fy)		gtő	r <sup>at</sup> nautsha		2-6-20				Virginia	
Bal	permit Deper Impor any in		21. Signature of Funeral Service Lio	Rickma			Name and Address itzke Fun 555 Twin	eral Knoll	Homes s Road	a Corr	umbia	., Mary	land 210	45
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that caused one cause on each lin	the death. Do	not ent	er the mode of dyin	g, such as	cardiac or re	espiratory arre	est,		Approximate Interval Between Onset and Deatl	1
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)		omy ope							-	le years	
ľ	Examiner			Due to (or as a	a consequence	9 (01):								
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	a consequence	of):								
	cate be executed physicien and the burial-transit	Examiner	Caues (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence	of):								
68760,	be ex sicien burial			d	2 Johnsaysbride	, 01).								
_		edicai		_ 0										
.O. Box	that the death certific led by the attending p detached for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								23d	f. Date of delive Month	very Day Year		
<u>a</u>	faw requires that the as been signed by th 2 should be detache	by Ph	Part II. Other significant conditions	contributing to death bu	ut not resulting	in the u	nderlying cause give	en in Part I.		23e. Did tob	acco use	contribute to	the cause of death	?
rds	w require been sig should b									1 🗀 Ye	s 2 🗆 N	√lo 3 XPro	bably 4 Unkn	own
of Vital Records,	6 7 6	Completed								24a. Was ar autops perform 1 ☐ Yes 2	У	24b. Were aut prior to c death? 1 ☐ Yes	topsy findings avail ompletion of cause 2XNo	able of
'ita	lcian: Th	BeC	25. Was case referred to medical examiner?						of Death (C	Check only on				
of V	shys this al dir	၉	1 ☐ Yes 2 No 27. Manner of Death	Hospital: Impatie		utpatier Time o	The Stiller	4 🗀 Nu	7	5 Reside			ify)	
Ou	ling After fune	tion	2 Accident 5 Pending investigate	(Month, Day	Year)	Injury	Wor	k?" Yes 2⊡i		2. 0630/100 /10	ow anjuly of	CCUTTEG		
Division	l or Attendi after death. Director: A I in by the fu	Certification:	3 Suicide 6 Could not determined	De Ogo Place of Inju		arm, st	reet, factory, office		28f	Location (St. City or Town		lumber or Ru	ral Route Number,	
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medical C		hysician: To the best of miner: On the basis of and manner sta	examination a									
	To the To the Comple	Me	29b. Signature and title of certifier				29c. Licens			25	9d. Date s	signed (Month	, Day, Year)	
)	1.1		DA Enck	MD			174	712		/	Voven	nber. T	,2006	
IF	111		30. Name and address of person who		eath (Item 23a	(Type,	Print)	0.1	0				F	
~	Sta	ite	31. Date filed (Month, Day, Year)	32. Rigistra	ar's Signature	N	Greene	.76	1001	timov	C , 1	10 7	1201	
	Registi		NOV 1 3	2006	Alexe Ale	1	No.							

06-08435 Flossie Miller

# Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygien

lossie ivillier		- For State	of Maryland / Departm <i>Certific</i>	nent of Health an cate of Death	ia ivientai Hyg	lene Rea. No	2000	2570
Physician	n/	Registrar  1. Decedent's Name (First, Middle,La	st)	· ·- ·-		Date of Death	200	3. Time of Death
Medical Examin		4a. Facility Name (if not institution, gi		TAD City Town or	. Location of Death	Month Day November 6, 2	2006 c. County of Death	1645 hrs
		711 East 21st Street	ve street and number)	Baltimore	Location of Death	1	NA	
Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs. last bi	irthday) If Under 1 Yea Months Day		8. Date of Birth(MN	Foreig	hplace (State or
Director		71 / / / / / / / / / / / / / / / / / / /	M 2 PF 17	Yrs.		MAY 31, 1	929 COI	intry) Md-
any	-	Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	n or Location		<i></i>		10d. Inside City Limits
and show	5	ma NA	7 BAI	TIMORE				1 Ves 2 No
Maryl: r 28a-f	rect	10e. Street and Number	et Cl. T	10f. Zip Code		10g. Ci	tizen of What Cour	itry?
suth with the Maryland items 23a or 28a-f show any ast be notified at once.	Funeral Director	711 EAST 21	12. Was Decedent Ever in U.S.	13. Was Decedent of Hi	Spanic Origin? (Spec	ify Yes or No-	U D H	can Indian, Black,
leath w	nue	1 Never Married 2 Marrie			n, Mexican, Puerto Ri		White, etc.	
s after or ral", o	현		d If Yes, Give Year or Dates:	1 Yes 2 No			10 [	ACK
2 hour "natu	ompleted	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	College (1-4 or 5+)	<ul> <li>Decedent's Usual Occupation</li> <li>during most of working life</li> </ul>	e. DO NOT use retired	1)	Kind of Business/li	
5-0036 ited within 7 Hygiene. I other than	ם	10		WAITRE.	22	1	ESTAU	RANT
♥ 등 뜻 를 됩	ပ၂	17. Father's Name (First, Middle, Las		ller	18. Mother's Name (F	00	n Surname)	
2121: ould be fil Mental E marked ic event,	9 B	19a. In ormant's Name/Relationship (	Type Print ) 1	9b. Mailing Address (Stre	et and Number or Rur		City r own, State,	Zip Code)
ore, MD ss I and 2 sho of Health and If item 27 is		KENNETT.	JAMES	106 PAIME	Ho DR.		rood mo	1.21040
of Heal		2ba. Method of Disposition  1 Burial 2 Cremation 3		e of Disposition (Name of ce latory or other place)	emetery, C	Date / 200	. Location City or	Town, State
Baltimore, MD pernit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati.	-	4 Donation 5 Other Specification 21. Signature of Funeral Service Lice		MEMORIAL 22 Name and Address	-PK 11/14	1200611	indson	mill ma
Bal permi Depa Impo injur		Distance of Foliaria Service Lice	ns me	MARSHA	politacilloni	// 4 /-	to my	2/213
Physician		23a: Part I. Enter the disease, or comfailure. List only one cause on e	oplications that caused the death. Do each line.	not enter the mode of dying				Approximate Interval Between Onset and
/Medical Examiner	1	Immediate Cause (Final disease or condition resulting in death)	Atherosclerotic Cardiovasc	cular Disease				Death
)		Sequentially list conditions,	Due to (or as a consequence of):					
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of):					
, / p ;	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):					
executed an and al - transi		UNPENDED	x AMENDED 17 per fl	h g <b>861 11-13</b> -	-06 vt.			
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and lumeral director, page 2 should be detached for use as the burial - transit	Medical	IF FEMALE:	23c. If yes, outcome of pregnance			2	3d. Date of delivery	
68760, certificate be nding physiciase as the buri		23b. Was decedent pregnant in the past 12 months?	1 Live birth  Pregnant at time of	2 Fetal death 3	Ectopic pregnance		-	ay Year
Division of Vital Records, P.O. Box 687 tal or Attending Physician: The law requires that the death certific its after death.  31 Director: After this certificate has been signed by the attending plot in by the funeral director, page 2 should be detached for use as the	Physician/	1 Yes 2 No 9 Unknow	7	5 Other (Specify)				
P.O. Box es that the death igned by the atterped detached for u	by Ph	Part II. Other significant conditions	contributing to death but not result	ting in the underlying cause	given in Part I.			the cause of death?
S, P quires t en signald be d						1 Yes 2	T	ably 4 Unknown topsy findings available
cord faw red has bee	Completed					autopsy performed	prior to c	ompletion of cause of
Re( r: The lificate r, page		25. Was case referred to medical		26 Plac	e of Death (Check on	1 Yes 2	N 1 Ye	s 2 No
Vital ysician his cert	o Be	examiner?	Hospital: 1 Inpatient 2 ER/	/Outpatient 3 DOA	Other Nursing		dence 6 🗸 Other	: Scene
of or ing Ph	-1	27. Manner of Death	28a. Date of Injury (Month, Day, Year)			3d. Describe how in	njury occurred	
Sion Mttend death.	gtio	1 Natural 5 Pending 2 Accident Investiga	ation		Yes 2 No	26.1 4: 40:		
Divis	Certification:	3 Suicide 6 Could no determin	ot be ed (Specify)	, farm, street, factory, office	building, etc.	or Town, State)	and Number or Ru	ral Route Number, City
hou hou		2005 Cortifier	cian: To the best of my knowledge, o	death occurred at the time, of	date and place, and du	ue to the cause(s) a	and manner as start	ed.
Division of Vital Records, To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should	Medical	one) 2 Medical Examin	er: On the basis of examination and/o and manner stated.					
	Σ	20b. Signature and title of certifie	0		.M.E.		Date signed <i>(Mor</i> ovember 7, 200	
<b>2</b>		30 Name and address of person who	completed cause of death (Item 23a					
2			stant Medical Examiner 1	11 Penn Street, Balti	imore, MD 2120	I		
Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signature	Legal 9				
Regist	τij	NOV 1 3 20	JUD KARAGE SS	17				

State of Maryland / Department of Health and Mental Hygien 2005 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year ROSALIE G. MINNICK NOV 2006 11:00A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9011 Perryvale Rd. Baltimore Perry Hall If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M XXF Director 219~38~0694 65 Yrs Dec. 12,1940 Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ Iteme 23a 9011 Perryvale Rd 21236 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2√ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No ģ 3 ☐ Widowed 4 ☐ Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) School System 12 yrs. N/A Cafeteria Worker 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 Is marked oth any njury or other treumatic event SIDES. 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ <u>William Karczeski</u> Leona Steg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9011 Perryvale Rd. Baltimore, Md. 21236 Edward L. Minnick, Sr. (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XY Burial 2 ☐ Cremation 3 ☐ Removal from State St. Michael's L.C.Cem. 11-11-2006 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Lassann Funeral Home 6. 7. assahn 7401 Belair Rd. Baltimore, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician cerebral vascular accident disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 🗆 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autops, performed es 2 No 1 ☐ Yes After this certification 25. Was case reterred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the I 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide o the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D45 904 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9524 Belai KRISTINE C. SALV Baltimore 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 1 3 2006

OSAliE

			1 - For State Registrar	State of Mary		artmen rtificat			ind M		giene Reg. No 20	06	35703
	Physici		Decedent's Name (First, Middle, Last)     RONALD	EDWARD	McCU	BBIN				2. Date of Dea Month Novembe	er 08,	2006	3. Time of Death 1:20 p M
5	/Medic Examir		4a. Facility Name (If not institution, give s Joseph Ritchie				Town, or				4c. Count	y of Death	
	Funeral Director		5. Social Security Number 6. Security Number 217–40–8308 Usual Residence of Decedent		yrs. last birthday 64 Yrs.	) If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day Oct. 3	v. Year)	9. Birthp Cour Mar	place (State or Foreign orry) yland
	th the Maryland or 28a-1 show s notified at	lirector	10a. State 10b. County  Maryland Anne A  10e. Street and Number	rundel		Glen E	Code				10g. Citizen of	What Cour	Od. Inside City Limits 1 ☐ Yes 2 🗹 No htty?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show ship fourty or other traumatic event, tra Medical Exarting trust to rotified at 2006.	by Funeral Director	102 North Crain Hv  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	y. Apt. 96: 12. Was Decedent Ever Armed Forces? 1 □ Yes 2 Ø No If Yes, Give Year or Dates:		Was Deced If Yes, spec	lent of Hi	.061 spanic Orig n, Mexican, Specify:	jin? (Spe , Puerto l	cify Yes or No- Rican, etc.)	U.S	ce - Americ ick, White,	etc.
Maryland 21215-0036	2 should be filed within 72 hours after and Menial Hygiene. Is marked other than "natural, or is marked other than "natural, or is aumatic event, tre Medical Exami	Completed I	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	(Give	edent's Usua e kind of wor DO NOT us ONCESS	rk done d se retired;	uring most	of workin	ng	16b. Kind of E		dustry
yland	ould be filed Mental Hyg wrked othe	To Be C	17. Father's Name (First, Middle, Last) Willian	McCubb				Fı	rance	es C	Maiden Sumai ampeggi		
	ges 1 and 2 sh I of Health and If Item 27 is m or other traum		19a. Informant's Name/Relationship (Ty)  Doris J. Luangrangs  20a. Method of Disposition  1 ☑ Burial 2 □ Cremation 3 □ R	see (in-law	) 8152 tob. Place of Disp cemetery, cre	Bell osition (Name of matory or of	Towe	er Cro	ossi D	ng Pasa ate	20c. Location	aryla - City or To	and 21122 own, State
Baltimore,	permit. Par Depertmen important: any injury.		4 Donation 5 Other (Specify)  21. Signature of Funeral Service License			2. Name an	d Addres	s of Facility			Glen Bu ome P.A na, Mar		Maryland 21122
>	Physician /Medical Examiner		23a. Part. Enter the disease, or complished, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the e cause on each line.  Due to (or as a co	death. Do not en		e of dying						Approximate Interval Between Onset and Death
8760,	cate be executed physicien and a the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co									
O. Box 6	death certifi e ettending id for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of print 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	⊒Ectopic pro						ite of delive	ery Day Year
ords, P.	requires that the een signed by th hould be detache	ted by P	Part II. Other significant conditions con	tributing to death but no	ot resulting in the u	underlying ca	ause give	n in Part I.			obacco use con es 2 No	tribute to th	ne cause of death? ably 4 Donknown
al Reco	The lar	Completed							_	24a. Was a autop perfor	med?	prior to cor death?	psy findings available inpletion of cause of 2000
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours elter death.  To the Funeral Director: After this certific completely filled in by the funeral director.	ation; To Be	27. Manner of Death  1 Natural 5 Pending 2 Acciden investigation	ospital: 1  Inpatient  28a. Dale of Injury (Month, Day Ye	2 ER/Outpatie		8c. Injury Work	r. 4□Nur	sing Hon				n hopice
Divis	ital or Att urs efter de ral Direct	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	ipecify)					City or Tow	m, State)		l Route Number,
	the Hosp thin 24 hor the Fune mpletely fi	Medical	29a. Certifier 1 Certifying Physical Certifier 2 Medical Examinate And title of certifier	ician: To the best of meer: On the basis of exa and manner stated.	y knowledge, dea umination and/or in	vestigation,	in my op	inion, death	l place, a	d at the time, o	date and place,	and due to	the cause(s)
	Z Will		Holm E	www "	no	6	256	211			29d. Date signe	06	
	()		30. Name and address of person who do	mpleted cause of death  W.W. M.  38. Registrar's	3001	S. Ha	1180	er S	7. E	Baltom	lor, m	0 21	225
	Sta Registi		NOV 1 3 2006	Esta care	B. Ba	eles o							

11/8/06

forald E. mccubbin

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 8:15 a 1. Decedent's Name (First, Middle, Last) <sup>D</sup>2, 2006 **Physician** Ethel Η. Myers November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Ridgeway Manor Nursing Home Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year July 3, 19 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last hirthday **Funeral** Days Hours 94 1 M XX 215-07-0344 1912 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show ral", or Items 23a or 28a-f sh Examiner must be notified 1 ☐ Yes 2 No Director Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3529 Lakeway Drive 21042 "natural", or items 23a United States Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: White Specify: ģ 3 Nidowed 4 Divorced Year or Dates: Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Worker Retail Sales 12 should be filed whand Mental Hygiel injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: if Item 27 is marked t any injury or other traumatic eve Charles Neighoff Katie Bullinger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Fred Neighoff / Nephew 3529 Lakeway Drive, Ellicott City, Maryland 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Meadowridge Mem. Park 11/6/2006 Elkridge, Maryland 4 Denation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed Due to (or as a consequence of) P.O. Box 68760. ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate has 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Hospital or Attending 5 Pending investigation 1 Natural 2 Accident Injury To the Hospital or Attervents within 24 hours after death. To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 Could not be determined 3☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only

Registra

one)

29b. Signature and

31. Date filed (Month,

DHMH 17 Rev 1/2001

**ORIGINAL** 

29d. Date signed (Month. Dav. Year)

'6 M. Rollingthol Bully and 2/228

and manner stated.

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

no

Day,

			For Stete Registrer	State of Ma	arylar		artmen rtificat			ind M	-	giene	00	6	35705	
	Physici	an	1. Decedent's Name (First, Middle, FREDA V.								2. Date of Dea Month	Day		ear	3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution,	<u> </u>			4b. City.	Town or	Location o	f Death	11	40.	County of I	C) G	0-4-13 VW	_
	Examin	er	Southern Mary		zul 1	Center		nton							corges	
	Funeral Director		5. Social Security Number 217–26–6403			last birthday) Yrs.	If Under Months	1 Year Days	tf Under 2 Hours	Min.	8. Date of Birt (Month, Da) Feb. 26	h v, Year)	9.	Birthp	ace (State or Foreign try) Virginia	
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ity, Town or Lo	cation							1	0d. fnside City Limits	_
	Man,	tor	Maryland Prince	George's	Ter	mple Hi	lls								1 ☐ Yes 2 No	
	or 28	Dire	10e. Street and Number				10f. Zip					10g. Citiz	zen of Wha	t Coun	try?	
	e 23a	erai	4513 Akron Stre	12. Was Decedent I	Ever in I	J.S. 13. V	Man Door		748	nin? /Cno	aifu Van ar Na		Jnite			
<b>'</b> O	ritem ritem	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie	Armed Forces? ed 1 ☐ Yes 2 🕅					n, Mexican	, Puerto f	cify Yes or No- Rican, etc.)		Black, \		etc.	
93	ral', o	d by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes	2XI No	Specify:				Specify:		White	
21215-0036	within 72 hours after deeth with the Maryland ene. then "natural", or iteme 23a or 28a-f ehow ta Madigal Ezandiar must be notified at	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced	dent's Usua kind of wo DO NOT us	rk done d	uring most	of working	ng	16b. Kir	nd of Busin	ess/ind	lustry	
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nd	al Hyg	Bec	17. Father's Name (First, Middle, L	ast)					18. Mothe	r's Name	(First, Middle,	Maiden .	Surname)			
yla	ould b Ment harkac	ဥ		lbert Drummo	ond						May Ro					
Maryland	d 2 sh th and th and 7 is m traum		19a. Informant's Name/Relationshi			1					Route Numbe				200 <b>1</b> 8	
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	707 # Q		23a. Part1. Enter the disease, or of		MO11	1/3	7557 W	iscons	sin Ave	nue,	Bethesda	, Mar	yland	2081	4 Approximate	_
>	Pnysician /Medical Examiner		shock, or heart failure. List of Immediate Cause (Finat disease or condition resulting in death)  Sequentially list conditions,	aDue to (or as	e 1	Myoc	ardi	1		١	tion				Interval Between Onset and Death	
8760,	cate be executed ohysicien and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c												
P.O. Box 68	w requires that the death certifica been signed by the attending ph should be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Feta	al death 3	]Ectopic pr ] Other (sp					2	3d. Date of Month		ry Day Year	
	quires tha an signed uld be del	ed by P	Pan II. Other significant condition  Hypertens  Diabetes Ma		ut not res	sulting in the u	nderlying c	ause give	n in Part I.			baccous 'es 2□			e cause of death? ably 4 dUnknown	
of Vital Records,	The lar	Completed	Diabetes M.	ellitus				· · · · · · · · · · · · · · · · · · ·			24a. Was a autop perfor	med?	prior	to con	esy findings available aptetion of cause of	
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of	Phye this rat di	2	1 ☐ Yes 2 Ø No 27. Manner of Death			ER/Outpatien		A Othe 8c. Injury	4 🗆 Nui		ne 5 Resid			Specify	)	_
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	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edicai	29a. Certifier (Check only one)	Physicien: To the best of exeminer: On the basis of and manner sta	examina	owledge, death ation and/or inv	occurred vestigation	at the tim , in my op	e, date and inion, deat	place, a h occurre	nd due to the d ad at the time, d	ause(s) date and	and manne place, and	r as sta due to	ated. the cause(s)	
	To the To the comple	Σ	29b. Signature and title of certifier			P)		. License					signed (N			
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0	20'	l n	30. Name and address of person w		eath (Ite			tts F	Road. (	linto	n, Maryl	and	20735			
	Sta Registr		31. Date filed (Month, Day, Year)  NOV 1	32. Registra	ar's Sign		Carl	0			, ,					

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Shirley Noll Merkle November 5 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Hospice If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ XF 80 220-18-7625 April 16 1926 MD Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at Woodstock 1 ☐ Yes 2 No MD Director Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21163 USA 1950 Woodstock Road death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onen of Health and Mertal Hygiene. In: If item 27 is marked other than "natural", or lite inny or other traumatic event, the Medical Examiner iny or other traumatic event, the Medical Examiner. 1 Yes 2 X If Yes, Give Year or Dates: 2 XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Completed by Specify: white 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) school teacher education +6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hobart B. Noll Sr. Lillian E. Humphrey ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 Upnar Road, Baltimore, MD 21212 19a. Informant's Name/Relationship (Type. Print) Craig B. Merkle (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Department o Important: If any injury or Granite Presbyterian 11-9-06 Woodstock, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21, Signature of Funeral Service Licensee Dage Haight Spenbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death levicemia Immediate Cause (Final disease or condition resulting in death) **Physician** nontre /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, living to inmodule cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician use as t attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 Yes 2 WNo Month Day Vear 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No certificate has be rector, page 2 s 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) No Spice Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28b. Time of 27. Manner of Ceath 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death. Neral Director: A filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral C completely filled Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29b. Signature and

State Registrar

31. Date filed (Month, Day, Year)

AANW

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			State of N 1 - State Amend #10e Per FH (	larylan 3861 I	d/P398	artment of H )6 JH <i>rtificate of l</i>	lealth and I D <i>eath</i>	Mental Hy	giene Reg. No	2006	35707
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of D	eath Day	Year	3. Time of Death
	/Medic	al	Donna D  4a. Facility Name (If not institution, give street and numbe		Napoli		Location of Deatl	Novemb		2006 County of Deat	11:38 A <sup>M</sup>
	Examin	er	9114 John Simmons Street	/		Freder				ederick	
	Funeral		45 14 677 5	lge (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth av. Year)	9. Birt	chplace (State or Foreign ountry) t Virginia
1	Director		232-78-7844 TLIM 2ALF Usual Residence of Decedent		115.			Februar	7 28, 1	951   Wes	t Virginia
	ryland how		10a. State 10b. County	10c. City	y, Town or Lo	cation					10d. Inside City Limits
	he Ma 28a-f s otified	Director	Maryland Frederick		Freder				10- 00	zen of What Co	1 ☐ Yes 2 No
	3a or 3		10e. Street and Number John Simmons Street 9114 Simmons Street	<u>t</u>		10f. Zip Code 2170	)4			ted Sta	•
	ems 2	Funeral	11. Marital Status 12. Was Deceder Armed Forces	t Ever in U.	S. 13.	Was Decedent of H		pecify Yes or N		14. Race - Ame Black, White	ncan Indian,
36	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	<b>by</b> Fu	1 ☐ Never Married 2 ☒ Married 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates	] No		1□Yes 2☒No	Specify:	,			White
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21215-0036	within ane.	Completed	Elementary/Secondary (0-12) College (1-4o	5+)	life. i	DO NOT use retired emaker	i)	King		wn Home	<u>.</u>
0 0	filed v Hygie other i	Be Co	17. Father's Name (First, Middle, Last)		Trome	marci	18. Mother's Nar	ne (First, Middle			
/lan	uld be Mental Irked o	To B	Donald Bond				Daisy F	Ruth Phi	lips		
Maryland	l 2 sho and I is ma rauma		19a. Informant's Name/Relationship (Type. Print)	1	1	ng Address (Street			-		•
e,	Healti Healti tem 27		Bradford J. Napoli / Husba	20b. P	Place of Dispo	sition (Name of	i	Date		ck, Mar	yland 21704 Town, State
altimore,	Pages nent of int: if i		1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	e I	-	matory or other places. Cemeter	1 21011	ember 2006	Germ	antown,	Maryland
Balti	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service-Lieensee	M0130	Ro	2. Name and Addres	ss of Facility phrey Fune	ral Home,	Rockv	ille, In	1 20050 2005
F	- 10		23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each							Marylan	d 20850–2805 Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Aden	ocarc:						i	Onset and Death 14 Months
	/Medical Examiner		resulting in death)  Due to (or a	ıs a consequ	uence of):						
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	ecuted and transit	Examiner									
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Box	The law requires that the death cert ate has been signed by the attending tage 2 should be detached for use s	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcon	2 🗌 Feta	death 3	]Ectopic pregnancy	/		2	23d. Date of del Month	livery Day Year
P.0	the de y the s iched f	ysic	1 ☐ Yes 2 🛣 No 4 ☐ Pregnant 9 ☐ Unknown		leath 5L	Other (specify) _					
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ord	w require been si should b	eted						1	Yes 2	∑No 3□Pr	robably 4 □Unknown
or Vital Records,	he law e has b ge 2 sl	Completed					<del></del>	24a. Wa: auto peri	yzgo	24b. Were au prior to death?	utopsy findings available completion of cause of
ta		Be Co	25. Was case referred to medical				26. Place of De		ormed? 2 X No one)	1 ☐ Yes	2 No
> ×	hysici his ce il direc	To B	examiner? 1 ☐ Yes 2 █ No Hospital: 1 ☐ Inpa		ER/Outpatier		er: 4□ Nursing I			6 □Other (Spe	cify)
	Attending Physician: r death. ector; After this certific by the funeral director,		- Estadad	njury Day Year)	28b. Time o Injury	Wor	yat k? Yes 2∐No	28d. Describe	how injur	y occurred	:
Division	Attender death ector:	Certification:	3 Suicide 6 Could not be determined 28e. Place of	njury - At ho	ome, farm, sti	reet, factory, office	163 2 110	28f. Location	(Street an	d Number or Ri	ural Route Number,
	ital or irs afte rai Dir lled in l	Cert	25	etc. (Specif)					own, State		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After thi completely filled in by the funeral.	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the besise and manner and manner	of examina	wledge, deat ation and/or in	h occurred at the til ivestigation, in my o	me, date and place ppinion, death occ	e, and due to the urred at the time	e cause(s) e, date and	and manner as I place, and due	s stated. e to the cause(s)
	To the I within 2: To the I complet	Me	29b. Signature and title of certifier			29c. Licens			29d. Dat	te signed (Mont	h, Day, Year)
)							2234		Nove	mber 9,	, 2006
_	10			05 Co	ncord		Suite 300	, Kensi	ngto	a, Mary	land 20895
	Sta Regist		31. Date filed (Month, Day, Year) 32. Regin NOV 1 3 2006	strar's Signa	ature	wells)					

		4	For Amend Item 14 per SA/G863,01712  - State Registrar	artment of Health and M <b>//O/dhb</b> rtificate of Death	ental Hygiene	2006 35708							
	T-1		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death							
	Physicia		Richard Nelson		October 2	-8 20010 1900 M							
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Union Memorial Hospital	4b. City, Town, or Location of Death Baltimore		c. County of Death							
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth	9. Birthplace (State or Foreign Country)							
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	w w	ŀ	Usual Residence of Decedent         10c. City, Town or L           10a, State         10b. County         10c. City, Town or L	ocation		10d. Inside City Limits							
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	3a ol	<u></u>	838 Wellington Street	21211		USA							
	deat	Funeral		Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc. White							
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 🕅 No Specify:	,	Specify: black							
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ary	2 should be f and Mental I is marked of aumatic eve	Ĕ	19a. Informant's Name/Relationship (Type. Print) 19b. Mai	ing Address (Street and Number or Rum	al Route Number, City	or Town, State, Zip Code)							
ž	1 and 2 Heelth a tem 27 is			E. University Pkw	•	e, MD 21218							
ore	Pages 1		1 ☐ Burial 2 ☐ Cremation 3 ☐ Hemoval from State	osition (Name of Ematory or other place)	Date 20c. L	Location - City or Town, State							
Baltimore,	permit. Pag Department Important: I any Injury o		4□Donation 5 NOther (Specify) in state/  21. Signature Funeral Service Lensage Wade, Wiregton S	22. Name and Address of Facility tate Anatomy Board	(55 H, D	1							
ä	permit. Departn Importa any Inju		Jumillial F	altimore, MĎ 2120	1	Itimore Street							
			23a. Part1. Enter the disease, of complications that caused the death. Do not e shock, or neart failure. List only one cause on each line.			Approximate Interval Between Onset and Death							
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8760,	cate be executed physician and the burial-transit	al Ex	Due to (or as a consequence of):										
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	w requires that the deeth certific been signed by the attending p should be detached for use as	Physician/Me	1 Yes 2 No	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year							
P.0	d by the	Phy	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e. Did tobacco	use contribute to the cause of death?							
ds,	requires that the een signed by th hould be detache	l by	Tatti. Other Significant Conditions continuously to dealing of continuously in the	directlying sauce give in it are to	. /	2 No 3 Probably 4 Unknown							
COL	law requas been 2 shoul	lete			24a. Was an	24b. Were autopsy findings available							
or Vital Record	о <u>с</u> о	Completed			autopsy performed? 1 Yes 2 1	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No							
ita	iclan: Th certificate rector, pag	Be C	25. Was case referred to medical	26. Place of Deat	h (Check only one)	70 100 2010							
۲ <	S S	TOE	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 FER/Outpati	ent 3 DOA Other: 4 Nursing Ho	ome 5 Residence	6 □Other (Specify)							
o u	After t		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury		28d. Describe how inj	ury occurred							
Division	Attending r death. ector: After by the funer	icati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm,		28f. Location (Street a	and Number or Rural Route Number,							
<u>≥</u>	al or A s effer al Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town, Sta	ate)							
	To the Hospital or Attending Phymithin 24 hours efter death.  To the Funeral Director: After this completely filled in by the funeral is	ledical (	29a. Certifier (Check only (Ch										
	To the I within 2. To the I complet	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month, Day, Year)							
	⊢ <i>≶</i>		Michael Wilson. M.	O D00547	87 0	ctober 28,2006							
			30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)	. 1 1	Raltimore, MD							
	7.		31. Date filed (Month, Day, Year) 22. Registrar's Signature		spital	Editimore, MD							
	St Regist	ate rar	NOV 1:3 2006	all of									
			NITY 3 LUUU ABABAAA PA										

		•	For State Registrar	State	of Maryla	ind / De <i>C</i>	partment of F ertificate of	lealth ai Death	nd Mei		ene 0	06	35709
			1. Decedent's Name (First, Middle,	Last)					2.	Date of Death Month	Day	Year	3. Time of Death
	Physici /Medic	_	Woodin	н.	(	swald	. Sr.		N	OVEM.BE			6:35 PM
)	Examin		4a. Facility Name (If not institution,	give street and n			4b. City, Town, o	Location of			4c. County		•
			Future Care o	f the Ch	esapeak	te	Arnold				Anne	Arun	del
	Funeral			6. Sex	7. Age (In yr		Months Days	If Under 24 Hours	4 Hrs. 8. Min.	Date of Birth (Month, Day,	Vear)	9. Birthr	place (State or Foreign
	Director		213-32-7872	1 <b>∑</b> M 2□F	72	Yrs	. Month's Days	riodis		c. 28,	1933_	Mary	
	pu ,		Usual Residence of Decedent		140.								
	aryla shov	_	10a. State 10b. County		100.	City, Town or	Location					,	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	8a-f	cto	Maryland Anne A	rudne1		dento							
	or 2	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of	What Cour	ntry?
	eth v		2605 Clarion Ct				2111				USA		
	within 72 hours after deeth with the Maryland ene. than "neturel", or Items 23e or 28e-f show ite Madical Exercites coust be multified at	Funeral	11. Marital Status	Armed F		U.S. 1	<ol><li>Was Decedent of H If Yes, specify Cuba</li></ol>	ispanic Origi ın, Mexican,	in? (Specify Puerto Ric	y Yes or No- an, etc.)		ce - Americ ck, White,	
5	s after	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	ed 1∐Yes IfYes,G Yearor	2 ☑ No live		1 ☐ Yes 2 ☑ No	Specify:			Specif		
2-003p	hour tural	D C	15. Decedent'		Dates:	162 Do	cedent's Usual Occup	ation			6b. Kind of B		ite
<u>.</u>	n 72 n na	Completed	(Specify only highest	grade completed		(G	ive kind of work done on the contract of the c	during most o	of working	'	bu. Kind of B	usiness/in	dustry
7	withi ene.	ш	Elementary/Secondary (0-12)	College 2	(1-4or 5+)			,			Constr		
<b>7</b>	Hygi Hygi ther int,		17. Father's Name (First, Middle, L			COL	ntractor	18. Mother	's Name (F	irst, Middle, M			11
yland	2 should be filed within and Mental Hygiene. Fis marked other than "raumatic avant, the Marked	o Be	Hanly Wood		oswald.	Sr.			eanor				uce
<u></u>	mark mark	၉	19a. Informant's Name/Relationsh		, owara,		ailing Address (Street				City or Town		
<u> </u>	id 2 s lth ar 27 ls treu		Woodin H. Oswal		Son)		l Norhurst						
စ်	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23s or 28s-f show says injury or other traumatic svant, it is Madical Examilities must be notified at an once.		20a. Method of Disposition		20b	. Place of Di	sposition (Name of		Date		Oc. Location		
ᅙ	ages ant of t: If it		↑ Burial 2 Cremation 4 Donation 5 Other (Sp		n State		rematory or other place		1/0/0	16 P	01+1ma	V	awatan d
saitimore,	artme ortan ortan injury		21. Signature of Funeral Service L		140	oudon i	Park Cemete 22. Name and Addre						aryland
ğ	Depi impo impo sny		2 // olgradio of ranous device	-			3620 Will						
			23a. Part 1. Enter the disease, or o	complications that	caused the de	ath Do not						7 212	Approximate
			shock, or heart failure. List of Immediate Cause (Final	only one cause on	each line.								Interval Between Onset and Death
1	Pnysician /Medical		disease or condition resulting in death)				RONIC OBS	TRUCTO	v = L	4NG D	ISEAS	E	
	Examiner			Due to	o (or as a cons	equence of):							
		10	Sequentially list conditions,	b. — Due to	(or as a cons	Mineriae offi							
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8/60,	cate be executed physicien and the burial-transit	cai											
ğ		O		0.									
×	certii nding use a	Z.W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	utcome of preg	nancy					23d Da	ite of delive	20/
X Q Q	death certif e ettending id for use as	Physician/Me	in the past 12 months?		birth 2 🗍 Fe		3 Ectopic pregnancy 5 Other (specify)				1	onth	Day Year
j.	y the	ıysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unki									
1	that led b deta	4	Part II. Other significant condition	ns contributing to	death but not r	esulting in th	e underlying cause giv	en in Part I.		23e. Did toba	acco use con	tribute to th	ne cause of death?
ecords,	w requires that the death certif been signed by the ettending should be detached for use as	d by								10 Ye	s 2 No	3 Prob	abiy 4 🗆 Unknown
ខ្ល	law req as beer 2 shou	iete						•		24a. Was an	24h	Were auto	nev findings available
Ů Ľ	slcian: The law certificate has t irector, page 2 s	Completed								autopsy	ed?	death?	psy findings available mpletion of cause of
VITAI	n: T ificat or, pa	e C	25. Was case referred to medical					45.01				1 🗆 Yes	2 No
	Physician: this certific ral director,	O B	examiner?	Hospital:	Manation 0	C = 0.0	tient 3 DQA Oth			5 🗌 Resider		40	
5	Phys r this stal di		27. Manner of Death	Advisor	of Injury nth, Day Year)					Describe how			y)
0	iding Phy th. : After thi funeral	tio	1 Pending 2 Accident investig		nth, Day Year)	Inju	y Wor	k? Yes 2∐No			, ,		
UIVISION	Atter dea ctor y the	fica	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place	e of Injury - At	home, farm,	street, factory, office			Location (Str	eet and Numt	per or Rura	I Route Number,
É	spitel or Attending Fours effer death. Serel Director: After filled in by the funera	Certification:	4 Homicide	build	ding, etc. (Spe	cify)	, , , , , , , , , , , , , , , , , , , ,			City or Town,	State)		
	spite nours naral		29a. Certifier 1 Certifying	Physician: To th	ne best of my k	nowledge, d	eath occurred at the tin	ne, date and	place, and	due to the car	use(s) and ma	anner as s	tated.
	To the Hospitel c within 24 hours of To the Funeral D completely filled in	Medical	(Check only 2 Medical E	xaminer: On the	basis of exami nner stated.	nation and/o	r investigation, in my o	pinion, death	occurred a	at the time, da	te and place,	and due to	the cause(s)
	To the within To the compl	×	29b. Signature and title of certifier				29c. Licens	e number		29	d. Date signe	d (Month,	Day, Year)
			Monegi	MS			D57	531		No	DVEMBE	R 06	,2006
	(.)		30. Name and address of person v	vho completed car	use oil death (It	em 23a) (Tvi	pe, Print)						
(	9							e m	D 21	10久			
	Sta	te	31. Date filed (Month, Day, Year)	32.	Registrar's Sig	nature		1					
	Registr		NOV 1	3 2006	Klesne	K	Brock						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 () () 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 11:17 AM 2006 Margaret E. O'Neill 01 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore HOSPITAL If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex Days Months Hours 1 ☐ M 257 F 1912 Maryland 94 214-07-1311 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County 1 Yes 2 No Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 715 Maiden Choice Lane #CR616 21228 USA 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home 12 0 housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Margaret Fogtman William Joseph Leasure 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2122 715 Maiden Choice Lane #CR616 Catonsville, MD William O'Neill/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) State Anatomy Board 655 W. Baltimore Street 21. Signafure of Euneral Service Licensee Ronald S. Wade Director m Baltimore, MD 21201 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final POXIG disease or condition resulting in death) Due to (o pleural Effusion CHF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 1)Isease 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown COPD 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No 1 Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1' Inpatient 3 DOA 2 ER/Outpatient

/Medical Examiner The law requires thet the death certificate be executed 四四 o Records, this certificate has of Vital

al or Attending F sefter death.

within 24 hours e To the Funeral

Division ARGA

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filled in by the fu

**Physician** 

/Medical

Examiner

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Funeral

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Completed

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**Funeral** 

Director

1 and 2 should be filed within 72 hours after death with the Marylan Heelth and Mental Hygiene.

am 27 is marked other then "natural", or items 23s or 28s-f show ther traumatic event, the Medical Examinar must be notified at

permit. Pages 1
Depertment of He
Important: If iter
any injury or oth

**Physician** 

Baltimore, Maryland 21215-0036

Examine Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 📆 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Be Completed 25. Was case referred to medical examiner? Certification: To 1 ☐ Yes 2 No 27. Manner of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

2006.

NOVOI.

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

30. Name and address of person 15 beth NI

31. Date filed (Month, Day, Year) NOV 1 3 2006

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		•	For State	State of Ma	arylan		artment of H rtificate of L			iene eg. No.200	6 35711
			Registrar  1. Decedent's Name (First, Middle, Las	t)					2. Date of Dear	th	3. Time of Death
	Physicia		GERALDINE		Ter	A			NovomB		0500AM
	/Medic Examin		4a. Facility Name (If not institution, give		, -		4b. City, Town, or	Location of Death	i Cycric)	4c. County of	
	LAdimii	Ç1	FUTURECARE	CheSAF	PEAK	e	ARN	CLD		ANNE	PENDEL
	Funeral		5. Social Security Number 6. Se	7. Age		last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year) 9	Birthplace (State or Foreign Country)
	Director		220–07–3067	M 20XF	86	Yrs.	Months Days	riodis Willi.	May 18,	1920 N∈	w Jersey
	D >	-	Usual Residence of Decedent  10a. State 10b. County		10c City	y, Town or Lo	ncation				10d. Inside City Limits
	ehov	7	,								1 ☐ Yes 242XNo
	28a-f	ect	Maryland   Anne Aru	ndel	GIE	en Burr	10f. Zip Code		1	0g. Citizen of Wha	at Country?
	within 72 hours after death with the Maryland ene. then "netural", or items 23a or 28a-f ehow the Maricul Examinar must be notitled at	Funeral Director	505 West Way				21061			U.S.A	
	ns 23	era	11. Marital Status	12. Was Decedent I	Ever in U.		Was Decedent of H	ispanic Origin? (Sp	pecify Yes or No-	14. Race -	American Indian,
	r Iter		1 Never Married 2 Married	Armed Forces?	io		If Yes, specify Cuba		Rican, etc.)		White, etc.
21215-0036	ral', c	d b	3∰Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes XXX No	Specify:		Specify:	White
2	72 h 'natu	etec	15. Decedent's Ed (Specify only highest grad	ucation de completed)		16a. Dece (Give	dent's Usual Occup: kind of work done o DO NOT use retired	ation during most of wor	king	16b. Kind of Busin	ess/Industry
2	hen.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	Book I		"		Grocery	Store
	filed v Hygie other t		17. Father's Name (First, Middle, Last)			DOOK 1	(eeper	18. Mother's Nam	e (First, Middle,	Maiden Sumame)	50010
ano	d be interested of the contract of the contrac	9 Be	Harry Blair					Helen			unk.
Maryland	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. is marked other then "natural", or items 23a or 28a-f show aumatic event, the Marical Exam for must be notified at	၉	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailir	ng Address (Street	and Number or Ru	ral Route Number	r, City or Town, Sta	ate, Zip Code)
	od 2:		Grace Ward (Daught	er)		505 7	West Way,	Glen Bu	cnie, Ma	ryland 21	061
<u>6</u>	s 1 a f Hea item othe		20a. Method of Disposition		- C	emetery crei	sition (Name of matory or other place	e)		20c. Location - Cit	y or Town, State
Ë	Pages nent of I ant: If its ury or o		1 ⊠ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Ho	lly Hi	ll Mem. G	ard 11/1	3/2006	Baltimore	e, Maryland
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic enurs.		21. Sto enture of Europeal Convince I to en	see		22	Name and Address Br	ss of Eacility UZdZinsk: Eastern	i Funera	l Home, I Essex. Ma	P.A. aryland 21221
			23a and Enter the disease, or comp	olications that caused	the death						Approximate Interval Between
	Physician		shock, or heart failure. List only immediate Cause (Final	one cause on each in		1/1/01	CARDI	AI IN	CARAT	whi	Onset and Death
	/Medical		dise se or condition resulting in death)	aDue to (or as	a conseq	uence of):	CARON	70 11	11001	~~~	219001
П	Examiner		Sequentially list conditions	b							
	אַ פּ	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	Due to (or as	a conseq	uence of):					
	and trans	Examiner	that initiated events resulting in death) Last	cDue to (or as	2 000000	uence of):					
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387	phys phys s the	dicai		d							
Box (	certif nding use a	J/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. Date of	of delivery
ă	that the death certifi led by the ettending I detached for use as	Physician/Me	in the past 12 months? 1 Yes 2 No	1☐Live birth 4☐Pregnant at			<pre>_ Ectopic pregnancy</pre> <pre>_ Other (specify)</pre>			Month	Day Year
P.O.	t the by the tache	hys	9 🗆 Unknown	9□ Unknown	_						
	res tha igned be del	by P	Part II. Other significant conditions of	,	ut not res	ulting in the u	inderlying cause giv	en in Part I.			ate to the cause of death?
Ž	w require been si should I	ted	HYPERTENSI	on					1 🗆 Y	es 2.⊡Mo 3	☐ Probably 4 ☐ Unknown
Vital Records,	a SC	Completed						<u>.</u>	24a. Was a autop perfor	med? pric	re autopsy findings available ir to completion of cause of th?
<u>a</u>			25. Was case referred to medical					26 Place of Dee	1 ☐ Yes th (Check only or		Yes 2 No
	Physician: r this certificatal director,	o Be	examiner?	Hospital: 1 ☐ Inpatie	ent 2	ER/Outpatier	nt 3 DOA Oth	er -		ence 6 Other	(Specify)
0	g Physical derection	n: T	27. Manner of Death	28a. Date of Inju	ry v Year)	28b. Time o	f 28c. Injur Wor			ow injury occurred	
Ö	Attending ir death. ector: Afte by the fune	atic	1 Natural 5 Pending investigation	1		, , , , ,		Yes 2 □ No			
Division of	2 1 2 2	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At ho c. <i>(Specif</i>	ome, farm, st	reet, factory, office		28f. Location (S City or Tow		or Rural Route Number,
	To the Hospital or Attant within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one)	ysicien: To the best niner: On the basis o and manner st	f examina	owledge, deat ation and/or in	th occurred at the tire	ne, date and place pinion, death occu	, and due to the or rred at the time, o	ause(s) and mann late and place, and	er as stated. If due to the cause(s)
	Fo the	Me	29b. Signature and title of certifier			in	29c. Licens	e number	2	29d. Date signed (i	Month, Day, Year)
			Muchay.	A. fry	ml		104	16360		VOVEMB	ot 11,2006
	5	1	30. Name and address of person who	completed cause of c	leath (Item	8 60/1/	Print)	HIGHWAN	MILLO	PESVIII O	Month, Day, Year)  OK 11, 2006  MO 21/08
	Sta Regist		31. Date filed (Month, Day, Year) NOV 1 3 2	32. <b>Ris</b> gistr	ar's Signa	ature	land o	········	1 (1000	- 20006	11/2
7	negisi	21	HATOL	A ASSA	Filed a	J-1 1	A STATE OF THE PARTY OF THE PAR				

Please Type or Print in Black Indelible Ink 06-08498 State of Maryland / Department of Health and Mental Hygiene Elaine E. Parks Certificate of Death 1- For State Rea. No Registrar 2 Date of Death Time of Death Decedent's Name (First, Middle,Last) Physician/ Month Day November 7, 2006 Year 1640 hrs Medical Examiner Elaine Elizabeth Parks 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore County** Halethorpe 2929 Delaware Avenue 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** oreign Hours Months Davs Mar. 22, 1947 MD Country) Director 59 212-46-9970 1 M 2X F Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 1 Yes 2 XNo Baltimore 23a or 28a-f show notified at once. Baltimore 28a-f show MD death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number United States 21227 2929 Delaware Avenue Race - American Indian, Black Funeral 11. Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No items If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc Armed Forces? Never Married 2 X Married 2 X No Vac White Yes 2 No specify. 4 Divorced f Yes, Give Year Widowed "natural", <u>چ</u> 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) permit Pages I and 2 should be filed within 72 I Department of Health and Mental Hygiene Important: If item 27 is marked other than "I injury or other traumatic event, the Medical E Seagrams Company Assembly Worker Baltimore, MD 21215-0036 18 Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Louise Purks William C. Seebach 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) ဂ္ 110 Stoney Bar Bluff Rd., Gransonville, MD 21638 Fleishell - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition

1 Burial 2 Cremation 3 crematory or other place)
West Arundel 11-10-2006 Odenton, MD Donation 5 Other Specify 22 Name and Address of Facility Ambrose Funeral Home, Inc. Signature 1328 Sulphur Spring Rd., Arbutus, MD 21227 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Intracerebral Hemorrhage Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical AMENDED UNPENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy phy, Bb. Was decedent pregnant in the past 12 months? Day Year 3 Ectopic pregnancy Live birth Fetal death use as Pregnant at time of death Other (Specify) 5 1 Yes 2 V No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? signed by 1 be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 V Unknown Emphysema Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? After this certificate has ✓ Yes 2 No page 26 Place of Death (Check only one 25. Was case referred to medical To the Hospital or Attending Physician: within 24 hours after death Be Other<sub>4</sub> examiner? Nursing Home 5 Residence 6 ✔ Other: Scene DOA Inpatient ER/Outpatient 3 1 🗸 Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 1 V Natural Yes 2 Pending Director: d in by the f Accident Investigation 28f. Location (Street and Number or Rural Route Number, City in by 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be 3 Suicide determined (Specify) Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29c. License number 29d Date signed (Month, Day, Year) Signature and title of pertifie November 9, 2006 O.C.M.E. Tame and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Laron Locke MD.

State

Registrar

31. Date filed (Month Of

2006

Please Type or Print in Black Indelible Ink 06-08057 State of Maryland / Department of Health and Mental Hygiene Stanley M. Parker Certificate of Death 1- For State Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Month Day October 26, 2006 Year 1230 hrs **Medical Examiner** Stanley M. Parker 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 1629 N. Gilmor Street 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 7. Age (In vrs. last birthday) 6 Sex 5. Social Security Number **Funeral** Country) Min Hours Months Days Director ept 1, 1957 North Carolina 118-50-7329 1 X M 2 49 Usual Residence of Decedent 10d. Inside City Limits Oc. City, Town or Location A U Y Yes 2 or 28a-f show Baltimore MD fied at once. with the Maryland Director 10g. Citizen of What Country 10e Street and Number 10f. Zip Code 1629 N. Gilmor Street 21217 USA 23a noti 14. Race - American Indian, 8lack Funeral 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12 Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? 1 X Never Married 2 X No Vec -4 Divorced If Yes, Give Year Yes 2 X No specify. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner. black à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 0 disabled none 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Allie Parker Gilford Nelson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print ) 2103 Callow Avenue Baltimore, MD Allie Brandon/mother 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) Burial 2 Cremation 3 Removal from State Department o in state Donation 5 X Other Specify 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street wade, Funeral Serv Ronald Baltimore, MĎ 21201 22 edused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Part List only one cause on each line Physician Between Onset and /Medical Death Hypertensive cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and cal UNPENDED AMENDED #23a,27,perME 11/30/06 TI hysician/Medi Box 68760, 23d. Date of delivery IF FEMALE. 23c. If ves. outcome of pregnancy phy the l 23h Was decedent pregnant in the 3 Ectopic pregnancy Year Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 9.0 2 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed Division of Vital Records, 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of has performed: death? certificate h ✓ Yes 2 No 2 No 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: Be Other<sub>4</sub> examiner? Nursing Home 5 Residence 6 🗸 Other: Scene DOA Inpatient ER/Outpatient 3 this 1 🗸 Yes 2 2 No 28c Injury at Work? 28b. Time of Injury After Manner of Death 28a. Date of Injury (Month, Day, Year) Certification n 24 hours after death

e Funeral Director: A
letely filled in by the fu 1 X Natural Yes 2 Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 1 one) and manner stated 29c. License number 29d. Date signed (Month. Day Year) 29b Signature and title of certifie O.C.M.E October 27, 2006

State

Registrar

111 Penn Street, Baltimore, MD 21201

30 Name and address of person who completed cause of death (Item 23a)

Carol Allan, MD

31. Date filed (Month, Day, Year) NOV 1 3 2006

Assistant Medical Examiner

Registrar's Signature

Grade from

State of Maryland / Department of Health and Mental Hygien@ 1 1 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Gwendolyn Poole NOVEMBER 6, 2006 7:40F M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔽 F 217-84-3314 43 Director 12/25/1962 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "naturs!", or itsms 23a or 28e-f shov svsnt, the Medical Examinar must be notified at 1 Yes 2 No Director MD Baltimore City 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4401 Fairview Avenue 21216 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 21 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: If Itsm 27 Is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Teacher's Aide Baltimore City Public Schools 10th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Vester David Poole Barbara Jean Rhodes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vacshon Brown / Son 2125 Clifwood Avenue; Baltimore, Maryland 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Trinity Cemetery 4 Donation 5 Other (Specify) 11/14/2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 111 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician RESPIRATORY FAILURE HOURS /Medical Due to (or as a consequence of): Examiner SHOCK HOURS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner inding physicien and use as the burial-translt AIDS MONTH Due to (or as a consequence of): BURKITT'S Completed by Physician/Medical LYMPHOMA MONTHS IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Por Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) deteched 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 8 212 No 3 ☐ Probably 4 ☐ Unknown should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy 2 NO 1 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To Impatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation hours after death. unaral Diractor: A sly filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier completely (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 06 D0063974 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person, IMRAN SIDDÍQI M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204

State Registrar

31. Date filed (Month, Day, Year)

NOV 1 3 2006

iled within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

Physicisn:

Hospital or Attending

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Division of Vital Records, P.O. Box 68760,

Show

32. Registrar's Signature

06-08412 Please Type or Print in Black Indelible Ink Larry Parks State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day November 5, 2006 1220 hrs Medical Examiner Larry T. Parks 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Baltimore St. Agnes Hospital 8. Date of Birth(MM/DD/YYYY) 9 Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Months Days Hours Min. Director 213-96-3655 Country) 1 X M 2 37 08/31/1969 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits any 10a. State 10b. County Y Yes 2 No 28a-f show MD Baltimore City "natural", or items 23a or 28a-f shov | Examiner m ist br notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 3924 Fairview Avenue 21216 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Never Married 2 Married 2 X No Yes If Yes, Give Year 3 Widowed Divorced 1 Yes 2 X No specify: Specify Black þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) If item 27 is marked other than " her traumatic event, the Medical Baltimore, MD 21215-0036 12th n/a 1andscape self-employed 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Lester W. Parks, Sr. Myrtle Parks Giles 19a. Informant's Name/Relationship (Type, Print ) ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myrtle Parks Giles / Mother 3924 Fairview Avenue; Baltimore, MD 21216 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State crematory or other place) Department of Important: 1 Mount Zion Cemetery 11/13/2006 Donation 5 Other Specify Baltimore, Maryland 0 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, MD 21217 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failure. List only one cause on each line. /Medical Death a. Complications of Gunshot Wound to Back Immediate Cause (Final disease ₹xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transit Physician/Medical UNPENDED AMENDED tending physician use as the burial IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Year Fetal death Day 2 Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? þ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of performed? ✓ Yes 2 No 2 No 1 🗸 Yes 25. Was case referred to medical 26. Place of Death (Check only one) æ Hospital: 1 🗸 Inpatient 2 Other Nursing Home 5 Residence 6 Other ER/Outpatient 3 ို 1 Yes No 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Subject shot **FOUND** Natural Pending 1 Yes 2 ✔ No Apr 26, 2006 0112 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 3900 blk West Forrest Avenue, Baltimore, Md. determined (Specify) Local Street

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: filled in by the within 2 **To the F** 

DHMH 17 Rev 1/2001

OCME 2006

30 Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 2006 State Registra

Signature and title of certifie

4 V Homicide 29a Certifier 1

Medical

111 Penn Street, Baltimore, MD 21201 32 Registrar's Signature

and manner stated

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

November 7, 2006

06-08361 Michel Lynn Reilly

## Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day November 4, 2006 0830 hrs **Medical Examiner** Michele Lynn Reilly c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Dundalk 631 Wilson Avenue 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** oreign Maryland Months Days Hours Director 41 Nov. 20, 1964 215 92 5633 1 M 2 X F Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b County any Yes 2 X No 28a-f show Baltimore Dundalk Maryland death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code notified 21224 5 631 Wilson Avenue USA - 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black 11. Marital Status 12. Was Decedent Ever in U.S must be White, etc. Armed Forces? 1 Never Married 2 Married 2 X No Yes White 4 X Divorced Give Year Yes 2 X No specify. 3 Widowed Specify <u>۾</u> 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 h ment of Health and Mental Hygiene tant: If item 27 is marked other than "n or other traumatic event, the Medical E Comple ltimore, MD 21215-0036 Bookkeeper Construction 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John C. Nadeau JoAnne Newell 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ashley Reilly (Daughter) 631 Wilson Avenue Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State permit. Pages Department of Important: I 11/7/2006 Baltimore, Maryland Bayview Crematory Donation 5 Other Specify 21. Signature of Funeral Service License 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Fastern Avenue Essex Essex Maryland 21221 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hea **Physician** Between Onset and failure. List only one cause on each line /Medical Death End stage liver disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). that the death certificate be executed and Physician/Medical X UNPENDED X AMENDED attending physician or use as the burial #1,23a,27,per, ME, G862, 12/16/06 TT Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day Live birth 3 Ectopic pregnancy Month Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify 1 Yes 2 No 9 V Unknown Q Unknown the red signed by the detacher 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ⋧ Yes 2 No 3 Probably 4 Unknown Completed s been s 24b Were autopsy findings available 24a. Was an prior to completion of cause of autopsy certificate has performed' death? Yes 2 V No 2 No 26. Place of Death (Check only one 25. Was case referred to medica director, Be Other<sub>4</sub> Hospital this c DOA Nursing Home 5 Residence 6 🗸 Other: Scene Inpatient 2 ER/Outpatient 3 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) After 28d. Describe how injury occurred 27 Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: or Attending 1 X Natural 5 Pending Yes 2 No hours after death To the Funeral Director: the Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be (Specify) Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie November 5, 2006 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day Year) **State** Registrar ORIGINAL

			For State	State of Mary	/land / l		irtment of F		_		006	35717
			Registrar  1. Decedent's Name (First, Middle, La	st)		Cei	uncate of t	Dealli	2. Date of De	Reg. No.		3. Time of Death
	Physici		Margaret	к.		Re	eier		Novemb	per 7	. 2006	2:30P M
>	/Medic Examin		4a. Fecility Name (If not institution, giv	e street and number)				Location of Deatl			County of Deat	
			244 Old Magothy B	ridge Road			Pasade				Anne Ar	
	Funeral		5. Social Security Number 6. S	TIM STORE	n yrs. last bii	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	y, Year)	9. Birt Co	hplace (State or Foreign buntry)
	Director		216-05-5138 Usual Residence of Decedent	94	·				Nov. 16	,191	1 Ma	aryland
	yland		10a. State 10b. County	10	c. City, Tow	m or Lo	cation					10d. Inside City Limits
	Ba-1 •	ctor	Maryland Anne A	rundel	Pasad	ena						1 Yes 2 70
	with th	Dire	10e. Street and Number 244 Old Magothy B	rideo Pood			10f. Zip Code 2112	2		-	en of What Co U.S.A.	ountry?
	eeth v	Funeral Directo	11. Marital Status	12. Was Decedent Eve	r in U.S.	13. \	Vas Decedent of H		pecify Yes or No		4. Race - Ame	rican Indian,
39	should be filed within 72 hours after deeth with the Maryland of Mental Hygiene. marked other then "naturel; or Iteme 23s or 28s-f ehow imalic event, the Madical Examinar must be notified at	by Fun	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		'	Yes, specify Cuba	Specify:	o Rican, etc.)		Black, White Specify:	e, etc. Nhite
Š	72 hou	ted	15. Decedent's E.		16a	. Deced	ent's Usual Occup	ation	kina	16b. Kind	d of Business/	Industry
21215-0036	within 72 ene. then "ne! he Medic	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	$\dashv$	life. I	ecutive S	1)	Killy	Fi	nance 7	Industry
	filed w Hygier other th		17. Father's Name (First, Middle, Last,	<u> </u>		ТУ	cutive 5	18. Mother's Nar	ne /First Middle			Industry
Maryland	ould be filed Mental Hygi arked other atic event, I	o Be	George	Α.	Br	own		Mary	ile (i iisi, wildale,	E.		<i>l</i> arwick
<u></u>	should nd Men marke imatic	7	19a. Informant's Name/Relationship (				g Address (Street		ral Route Numb			
	es 1 end 2 should b of Health and Ment I liem 27 is marked r other traumailce		Jean E. Reier (Da	ughter-In-La	w) 2	44 (	Old Magot	hy Bridg	e Road F	asade	ena, Ma	ryland 2112
ore	or oth		20a. Method of Disposition 1 Burial 2 Cremation 3	1	20b. Place o cemete	f Dispo	sition (Name of natory or other place		Date	20c. Loc	ation - City or	Town, State
altimore,	permit. Pages Depertment of Important; If It eny injury or o		4 ☐ Donation 5 ☐ Other (Specif	y)	Bayvi		Crematory					Maryland
Ba	permit. Page Depertment: Important; If eny injury o		21. Signature of Funeral Service Licer	bellins		22	Name and Addre ICCully-P 3204 Moun	olyniak tain Roa	Funeral d Pasade	Home ena, N	P.A. Marylar	nd 21122
			23a. Part. Enter the disease, or comshock, or heart failure. List only	plications that caused the one cause on each line.	death. Do	not ent	er the mode of dyin	g, such as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)		haryn		1 Canc	er.				Onset and Death
	/Medical Examiner		Tosuming in doding	Due to (or as a co	onsequence	of):						
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×	eath certifi attending p	/Me	IF FEMALE:	23c. If yes, outcome of p	regnancy					23	3d. Date of deli	in an
ROX	death atter	Iclan	23b. Was decedent pregnant in the past 12 months? 1 \( \subseteq \text{Yes} \) 2 \( \overline{A} \) No	1 Live birth 2 □ 4 Pregnant at time	Fetal death		Ectopic pregnancy Other (specify)			20	Month	Day Year
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Vital Hecords, P	sigr d be	d by Physician/Me	Part II. Other significant conditions of	contributing to death but no	ot resulting i	n the ur	iderlying cause giv	en in Part I.	23e. Did t		,	the cause of death? obably 4 Dunknown
Ö S	aw requ s been 2 shout	Completed							24a. Was		24b. Were au	topsy findings available
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/ita	iclen: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	11				26. Place of Dea	th Check only o	ne)		
	Phy this ald	2	1 Yes 2 No	Hospital: 1 ☐ Inpatient  28a. Date of Injury	2 ERVO	tpatien		4 Li Nui Siriy F	lome 5 Reside			cify)
0	ding h. After funer	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye		Injury	28c. Injun Worl	yat k? Yes 2∐No	28d. Describe I	iow injury	occurred	
Division of	Atten r deal ector: by the	ifica	3 Suicide 6 Could not b	e 28e. Place of Injury	At home, fa	arm, str	eet, factory, office				Number or Ru	ıral Route Number,
בֿ	rs afta	Certification;	4   nonlicide	building, etc. (S	эрөспу)				City or Tou	vn, Siaie)		
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After complately filled in by the funer	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	nysician: To the best of m niner: On the basis of exa and manner stated	amination ar	e, death nd/or inv	occurred at the tin restigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) a date and p	nd manner as place, and due	stated. to the cause(s)
	To th withir To th comp	Ň	29b. Signature and title of certifier	14			29c. Licens	e number		29d. Date	signed (Monti	n, Day, Year)
			<b>)</b> [1]	1/2			12 20	108			11/8/2	.006
	2		30. Name and address of person who					725	1.12	. 1.0.5	24	210/1
	Sta	te.	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	<i></i>	le boad !	414 00	- CLEND	N. N.	MA	21061
	Registr		NOV 1 3 200	6 Player	JA A	for	le					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 8, 2006 Physician 2:00 P. M November Robert Blair Richards, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Montgomery Hospice Casey House Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 13 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Year) Hours 1950 Washington, D.C 56 Director 213-50-3646 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any lijury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No **Funeral Director** Bethesda Maryland Montgomery 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number U.S.A. 20816 5007 Sentinel Drive, Unit 41 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Federal Government Publishing Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maxine Whitaker Robert Blair Richards, Sr. L<sub>o</sub>L 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10408\_Clinton Ave., Silver Spring, Maryland 20902 Kim Richards / Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Nov. 10 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2006 Montgomery Crematorium Bethesda, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chewy Chase, Inc. 23a. Part. Linter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximately Supervised Immediate C use Final disease or condition resulting in death) **Physician** Rectal cancer Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, IF FFMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4□ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 TNo 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 2**X** No Medical Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 1 ☐ Yes 2 ☐ No 1 🖂 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation Injury 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 💢 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) applications and applications are stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 9, 2006 20064615

Registrar DHMH 17 Rev 1/2001

State

C.

6001 Muncaster Mill Road, Rockville, Maryland 20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

/Geneviere Wroblewski

NOV 1 3 2006

31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of Maryland		artment of H tificate of L		Mental Hygier	2000	35719
4.	Physici	an	1. Decedent's Name (First, Middle, L.					2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Melvin Everett			41 65 T			10 2006	1:22a M
	Examin	er	4a. Facility Name (If not institution, gite Carroll Hospital			4b. City, Town, or Westmins			4c. County of Death Carro11	
	Funeral		Social Security Number     6.	Sex 7. Age (In yrs. In	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
87	Director		0/2 22 1/32	1 XM 2□F 78	Yrs.	Months Days	Hours Min.	July 15 1		ington, DC
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City	r, Town or Lo	cation				10d. Inside City Limits
	Maryl -f sho Lied a	tor	MD Somerse	t Ma	rion S	Station				1 Yes 2 No
	be filed within 72 hours after death with the Maryland tal Hyglene d other then "natural", or lteme 23a or 28a-f show event, the Medical Exam fact must be codified at	Director	10e. Street and Number	Thursday Day 4		10f. Zip Code			Citizen of What Cou	intry?
	e 23a		27366 Phoenix C	nurch Road  12. Was Decedent Ever in U.3	C 121	21838	incania Origina (C		SA 14. Race - Amer	iana ladina
0	r Item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No 194	5- 1	Vas Decedent of Hi f Yes, specify Cuba	n, Mexican, Puert	o Rican, etc.)	Black, White	
<u> </u>	ral', o	by	3 ☐ Widowed 4 ☐ Divorced	If Wes, Give Year or Dates: 194		1 ☐ Yes 2 📉 No	Specify:		Specify: Wh	ite
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ק פ	be filed within 72 tal Hygiene. d other then "nai event, the Madic	Be Co	17. Father's Name (First, Middle, Las	t)			18. Mother's Nan	ne (First, Middle, Maid		
<u>la</u>		To B	Melvin Everett	Roach			Mary	Evelyn		
Maryland	12 should hand 7 le m	1	19a. Informant's Name/Relationship Mrs. Nancy Roach					ral Route Number, Cit d., Marion		
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altimore,	Pages nent of int: If Its		1 ☐ Burial 2 ☐ Cremation 3 { 4 ☐ Donation 5 ☐ Other (Spec	Hemoval from State	-	natory`or other plac ty Cremat		2-06 Sy	kesville,	MD
Balt	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service Lice	insee	22	. Name and Addres	ss of Facility Ha	ight Funer	al Home &	Chapel
			23a. Part 1. Enter the disease, or cor	polications that caused the death				ville, MD		Approximate
	Dhysisian		shock, or heart failure. List only Immediate Cause (Final	y one cause on each line.  AMWOSC		6 · C	g, 3001 as cardiac	A) Collar	Disease	Interval Between Onset and Death
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9	entifica ling ph	Med	IF FEMALE:	00-16						
Rox	eath certific attending p	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnate 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of deliver Month	very Day Year
o.		hysi	1 Yes 2 No 9 Unknown	9□ Unknown						
<u>ര്</u>	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions	contributing to death but not resu	ilting in the ur	nderlying cause give	en in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ord	v requir been si should	ted						1 🗆 Yes	2 No 3 Pro	bably ÆGUnknown
Record	The law sate has b page 2 st	Completed			···			24a. Was an autopsy performed	prior to ci	opsy findings available empletion of cause of
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n of	er en	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of			28d. Describe how in		97
S	or Attending ifter death. Director: After in by the funa	catle	2 Accident investigate 3 Suicide 6 Could not	on he		M 1 🗆 '	Yes 2 □No			
Division	aftar of At Direct	Certification:	4 Homicide determine		me, farm, str	eet, factory, office		28f. Location (Street City or Town, St	and Number or Rur ate)	al Route Number.
	To the Hospitel or Attendin within 24 hours aftar death.  To the Funeral Director: At completely filled in by the fun		29a. Certifier 1 Certifying P	Physician: To the best of my know	wiedge, death	occurred at the tim	ne, date and place	, and due to the cause	e(s) and manner as	stated.
	To the Hi within 24 To the Fu	Medical	one) Z Medical Exa	and manner stated.	ion and/or in	estigation, in my of	oinion, death occu	rred at the time, date	and place, and due	o the cause(s)
)	Twit on on	2	29b. Signature and title of certifier	-		29c. License	: riumber / 名フュ / :	29d.	uate signed (Month)	Day, Year)
ì	0		30. Name and address of person who	completed cause of death (Item	23a) (Type	Print)	1145		, , , ,	0 346
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			5. Social Security Number 6. Sex	7. Age (Inlyrs.)	last birthday)	If Under 1 Year	tf Under 24 Hrs	8. Date of Birth	H	9. Birthola	ice (State or Fo	oreian
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	n deat	Funeral	11. Marital Status	Was Decedent Ever in U. Armed Forces?	S. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (S	Specify Yes or No- to Rican, etc.)		e - America ck, White, e		
36	tiled within 72 hours after death with the Maryland Hygiene. uther than "netural", or Itema 23a or 28a-f ehow with the Madical Exampler must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	1 XYes 2 ☐ No If Yes, Give Year or Dates:	†	☐ Yes 21X No	Specify:		Specif	whi	te	
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and	od la b →	Be	17. Father's Name (First, Middle, Last)  Robert Stanton					me (First, Middle, M NOWN	aluen suman	110)		
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ore	of He		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Re	emoval from State	emetery, cren	sition (Name of natory or other place			Oc. Location -			_ ,
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Division of Vital	r Attendl er death. rector: A	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	eet, factory, office		28f. Location (Str. City or Town,	eet and Numb State)	er or Rural	Route Number	
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	within To the	Me	29b. Signatule and title of certifier	. 11	7 1 1	29c. License	number	1/ 29	d. Date signe	d (Month, D	ay, Year)	
,	1		Vin nell	unstill	en, h	00-	5018	4 1	w	05,	200	6
4	1		30 Name and address of person who co	repleted cause of death (Item	1 23a) (Type.	Print) P/S	36(D)	st Brown	Unt	A. 6	1/Kria	100
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture	010	U CO.	10000			, - ,	1
	Registr		NOV 1 3 20	06 Pagasage	15 6	DEACE !					,	:

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) November 7, 2006 ar **Physician** 10:00 A.M Ε. Vernon /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Glen Burnie
Under 1 Year | If Under 24 Hrs. | 8. Date of Birth

Davs | Hours | Min. Juffenth 16ay, Yere 16 Mariner Health Care at North Arundel Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** MaryTand 1₩ 2□F 90 212-09-9362 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County e filed within 72 hours after death with the Marylar at Hygiene other than "nature!", or Items 23a or 28a-f show other than "nature!", or Items 23a or 28a-f show vent, the Macical Examiner must be notilliar a 1 ☐ Yes XX No Glen Burnie Anne Arundel Directo Maryland 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code United States 21061 311 Main Ave., S.W. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Inspector i. Pages 1 and 2 should be filed virtnent of Health and Mental Hygie rtent: if Item 27 is marked other thury or other traumatic event, in 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Katherine Lettaw Edgar South 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 311 Main Ave., S.W. Glen Burnie, MD 21061 Beulah South / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov. Date 20a. Method of Disposition Department of I Importent: If its any injury or of once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Denation 5 □ Other (Specify) Centreville Cemetery 2006 Centreville, Maryland 21. Signature of Foreral Service permit. 22. Name and Address of Facility Kirkley-Ruddick Funeral Home P.A. 421 Crain Hwy. S.E. Glen Burnie, MD 21061 CHI 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 141. CORONARY ARTERY DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dualto (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicier Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) signed by the a d be detached for 9 TUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an tor: After this certificate has the funeral director, page 2. autopsy performed? 1 🗆 Yes 2 \ No 1 Yes 2√2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 🖾 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ို 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Amatural 5 Pending investigation М 1 Yes 2 No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0054 M.V November 8, 2006 OUMAR YY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sterry Colon Burnie, MD. 21061 VERS LEY 45 OAKWOO DR-DONNA 31. Date filed (Month, 32. Registrar's Signature State Registrar

			For State Registrer	State	of Maryla	and / [	Departm <i>Certific</i>	ent of H ate of I	lealth a Death	and Me		ene	06	35722
	Dhusisi		Decedent's Name (First, Middle, L	ast)	Sophia	N	Shanta				2. Date of Death Month	Day	Year	3. Time of Death
	Physici /Medic					11.					Novembe	r 7, 2	2006	4:30P™
}	Examin	er	4a. Facility Name (If not institution, g Genesis Healt		ımber)		4b. (	Seve	r Location o				y of Death Arur	ndel
	Funeral			Sex 1 □ M 2 🗶 F	7. Age (In y		Mon	nder 1 Year ths Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	place (State or Foreign
	Director		214-01-6462 Usual Residence of Decedent	1 M 2 KM	94	<u> </u>	Yrs.				Mar 23,	1912	Ma	ryland
	/lend		10a. State 10b. County		10c.	City, Tow	n or Location						1	10d. Inside City Limits
	a-f ah	ctor	Maryland N/A						Balti	imore				1 XYes 2 No
	or 28	Director	10e. Street and Number 1516 Sycamo	ana Stna	o.t		10	Zip Code	21226		10	g. Citizen of US/		ntry?
	ne 23e	Funeral	1310 3y Callin		edent Ever in	ı U.S.	13. Was D			gin? (Spec	offy Yes or No-		ce · Americ	can Indian,
36	be filed within 72 hours efter deeth with the Marylend Ital Hygiene. Id other then "natural", or Items 23s or 28s-f show avent, the Medical Examination notified at	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed F	orces? 2 [X] No ive			specify Cuba s 2 ₩ No	Specify:	i, Puèrto R	ofy Yes or No- lican, etc.)	Special Special	ack, White,	<sub>etc.</sub> Mnite
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3	£ 2 € €	J.	19a. Informant's Name/Relationship	(Type, Print)			. Mailing Add	ress (Street		<u> </u>	Route Number,		, State, Zip	Code)
	27 tra		Annette A. Thomas		(Nie	ce)	46 G16	enda 1 e	Aven	ue, G	len Bur	nie, M	laryla	ınd 21061
altimore,	ö O		20a. Method of Disposition 1XC Burial 2 ☐ Cremation 3	□Removal from		cemeter	Disposition ry, crematory	Name of or other plac	(a)	Da	ite 2	Oc. Location	- City or To	own, State
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Ba	permit. Pag Department Important: I any injury o	N	21. Signature of Funeral Sprice Lic	11.01		cker	McCu	e and Addres	olynia	ak Fu	neral	Home,	P.A.	21225-1856
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that y one cause on	caused the deach fine.	eath. Do r	not enter the	mode of dyin	g, such as	cardiac or	respiratory arre	st,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_aALZ	MIE	ME	RS	1)6	ME	NT	IA		- 5	TYEARS
	/Medical Examiner		resulting in deathy	Due to	(or as a cons	sequence	of):							
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ŏ	eath certifi attending I I for use es	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou								23d. Da	ate of delive	ery
m ·	death	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No		birth 2 □ F nant at time o		3 ⊟Ectop 5 ☐ Othe	c pregnancy (specify)				M	onth	Day Year
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Records,	gne be o	Ď	Part II. Duras significant conditions	COMPOSITION OF		resulting ii	r the dilderly	ig cause give	en en raitt.		1 🗆 Yes	_/		pably 4 DUnknown
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<u>_</u>	ding f h. After funer	tlon	27. Manner of Death  1 Natural 5 Pending 2 Accident investigati	1	oth, Day Year		Time of njury M	28c. Injury Work	γατ k? Yes 2.⊟I		3d. Describe hov	v injury occui	rea	
Division	at or Attanding Physician: • elter death. • Diractor: After this certific d in by the funerel director.	Certification	3 Suicide 6 Could not determine	be 28e. Place	e of tnjury - A	t home, fa	rm, street, fa				Bt. Location (Stre City or Town,		ber or Rura	ll Route Number,
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	To the Hospital or within 24 hours eft to the Funeral Discompletely filled in	Medicai	(Check only 2 Medical Excone)	eminer: On the b	pasis of examiner stated.	ination an	d/or investiga	tion, in my of	pinion, dea	th occurred	d at the time, dat	e and place,	and due to	the cause(s)
	To the within 2 To the complet	¥	29b. Signature and title of certifier	4.1	MD			29c. License	e number		29	d. Date signe	Month,	Day, Year)
	m		pound s		LNTE	RNA	LME	MUNI	E D	511	04 N	DV 9	,21	006
_			30. Name and address of person who	ONDA,	4710	PEN		TONA	THEN	NUE	BAL	TIMO	RE	MD 21226
	Sta Registr		31. Date filed (Month, Day, Year)	32. F	Registrar's Si	gnature	esti s							
	riegisti	21	NOV 1 3 2006	No SELA	S 55	Of the State of	All All Sales							

Please Type or Print in Black Indelible Ink Donald A. Samuels State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2 Date of Death Month November 10, 2006 0530 hrs **Medical Examiner** Samue1 Donald. Ambrose 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A Harbor Hospital Center Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreian Country) Maryland Director 31, 1951 55 Jan. 212-56-7332 1 X M 2 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits s 23a or 28a-f show e notified at once. 1 X Yes 2 No 28a-f show N/A Baltimore Maryland death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21226 U.S.A. 3818 Fairhaven Ave. Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Married 1 Never Married 2 Yes Specify White 1 Yes 2 X No specify D 21215-0036 should be filed within 72 hours after 4 X Divorced If Yes, Give Year 3 Widowed Examiner "natural". ģ or Dates 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ten 27 is marked other than " traumatic event, the Medical ! N/A Handyman Construction Company 17, Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) and Mental H Edwin Samue1 Mattie Pitts Samue1 Be 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ပ 710 Heather Stone Loop Glen Burnie Maryland 21061 Phyllis L. Griffiths (Sister) t of Health a Pages 1 and 2: 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State crematory or other place) Baltimo
permit. Page
Department of
Important:
injury or oth Glen Haven Mem. Pk. 11/13/06 Glen Burnie Maryland Donation 5 Other Specify 2 Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 East Patapsco Ave. Baltimore Maryland 21225 21. Signature of Funeral Service Licenses **Physician** [2011]. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a gunshot wound of abdomen Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury trial initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live hirth 3 Ectopic pregnancy Month Year Fetal death Day past 12 months? 2 Pregnant at time of death Other (Specify 1 Yes 2 No 9 Unknown Unknown Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, P. 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b Were autopsy findings available autopsy prior to completion of cause of has performed? page 2 death? ✓ Yes 2 1 🗸 Yes No 25. Was case referred to medical 26 Place of Death (Check only one) Be examiner? Other<sub>4</sub> Inpatient 2 V FR/Outpatient 3 DOA Nursing Home 5 Residence 6 1 🗸 Yes ဂ No 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Nov 10, 2006 Subject found shot in vehicle Natural 0457 hrs 5 Pending Yes 2 🗸 No within 24 hours after death To the Funeral Director; in by the 2 Accident Investigation 2Be. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 4501 Pennington Avenue, Baltimore, MD determined (Specify) Vehicle in parking lot 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. November 10, 2006 D. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year)

32 Registrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

Year 3 2006

06-08553 Edward Strock

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

IWAIG SHOCK		State of Maryland / 1- For State Registrar	Certificate of Dea		ygiene Reg.	No. 2006	35725
Physici edical Exam	ian/	1. Decedent's Name (First, Middle,Last)  Edward Paul Strock			Date of Death     Month D     November 9		3. Time of Death 1641 hrs
		4a. Facility Name (if not institution, give street and number)  Prince Georges Hospital Center		y, Town, or Location of Death everly		4c. County of Death Prince George	s
Funeral Director			(In yrs. last birthday) if U	nder 1 Year If Under 24Hrs	8. Date of Birth (1	MM/DD/YYYY) 9. Birth	
Varyland <b>28a-f show any</b> <u>d.at.once.</u>	tor	MD Howard	10c. City, Town or Location		cott Cit		10d. Inside City Limits 1 Yes 2 No
h the Mary 3a or 28a- otified at	Director	4205 Brittany Dr.	10f. 2	Zip Code 2 1 0 4 3	10g.	USA	try?
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygene 27 is marked other than "natural", or items 23a or 28a-fshomante event, the Medical Examiner must be notified at once	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced If Yes 1 or Dates:  15. Decedent's Education (Specify only highest grade comparison.	50%-1952 <sub>1 Yes</sub>	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto  2 X No specify  Jal Occupation (Give kind of v	Rican, etc.)	14. Race - Americ White, etc.  Specify.  Sb. Kind of Business/Ir	Vhite
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hou nt of Health and Mental Hygiene tti. If tem 27 is marked other than "nati other tranmatic event, the Medical Exa	Completed	Elementary/Secondary (0-12)  College (1-4 or 5-4)	during most of v	working life. DO NOT use reti a cher		Educat	
ID 21215-0036 should be filed within 72 and Mental Hygiene 77 is marked other than matic event, the Medical	Be	17. Father's Name (First, Middle, Last) Paul Edward Strock		An	(First, Middle, Mai na Kova	ch	
- p = E E	1	19a. Informant's Name/Relationship (Type, Print)  Mrs. JoAnn Strock wife	e 4205 Br	ess (Street and Number or Frittany Dr.	Ellico	tt City,	MD 21043
Baltimore, I permit Pages I and Department of Healt Important: If item injury or other trat		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from Stat  4 Donation 5 Other Specify:		e Vet. 11/	14/06	Oc. Location - City or T	lle, MD
Physician Physician		21. Signature of Funeral Service Licensee  23a. Part I. Enter the disease, or complications that caused the service of the ser	22. Name a 3871 the death. Do not enter the modern the	and Address of Facility S 1 0 1 d Columb de of dying, such as cardiac of	ack Funi ia Pike rrespiratory arrest,	eral Home , E.C. MD shock, or heart	P.A. 21043 Approximate Interval
/Medical Examiner		failure List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a Multiple Injuries  Due to (or as a consect	quence of):				Between Onset and Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	quence of):				
executed an and al - transit	l Examiner	(Disease or light, / that kritisted events resulting in death) Last  Due to (or as a consect d.	quence of):				
760, cate be exe physician a	Medical	UNPENDED					
Box 6876 death certificat the attending phy of for use as the	sician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1	2 Fetal dea		ancy	23d. Date of delivery  Month D	ay Year
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death To the Funemal Director. After this certificate has been signed by the attending a completely filled in by the funeral director, page 2 should be detached for use as it	by Phy	9 Unknown	but not resulting in the underly	ring cause given in Part I.		cco use contribute to t	
of Vital Records, ag Physician: The law require the this certificate has been simeral director, page 2 should be	Completed				24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
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F Vita	10 B	TV Tes Z NO	nt 2 🗸 ER/Outpatient 3			sidence 6 Other:	
ivision of or Attending Platter death Director: After in by the funeral	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28b. Time of Injury 1527 hrs	28c. Injury at Work?  1 Yes 2 ✓ No	28d. Describe how Driver auto au		
Division tall or Attending as after death all Director: A led in by the fu	ertific	Suicide Could not be	ury - At home, farm, street, fact ergency Room		28f. Location (Street or Town, State Rt. 5 @ Rt. 236,	e)	al Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a Certifier 1 Certifying Physician: To the best of my one) 2 Medical Examiner: On the basis of exam and manner stated	knowledge, death occurred at	the time, date and place, and	due to the cause(s	) and manner as starte	
F 3 F 8	Me	29b Signature and title of certifier		29c. License number O.C.M.E.		9d. Date signed (Mon November 10, 20	
70		30 Name and address of person who completed cause of de Zabiullah Ali, M.D. Assistant Medical Ex	, ,	reet, Baltimore, MD 21	201		
Regis	State strar	31. Date filed (Month, Day, Year) 32. Redistrar	's Signature		-		
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	D .		Usual Residence of Decedent						11 00	0.004			
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	28a-f	rect	10e. Street and Number	Gomery 1	1010		RY VILLAC	16, II		g. Citizen of V	Vhat Cour	/\	
	3a or	Funeral Director	10215 KINDLY	COURT			2088	36		US		, .	
	ems 2	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was De	cedent of Hispanic Orio becify Cuban, Mexican	igin? (Specif	y Yes or No-	14. Race		an Indian,	
20	s after	y Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Tes 2 No			2 No Specify:		Sail, 010.7	Specify			
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2	and 2 sh salth and n 27 Is m		JENNIFER SMITH	MOTHER	100	0215 K						AGE, MI	1
ore,	es 1 a of Hea f Item r othe		20a. Method of Disposition	<i></i>	20b. Place	of Disposition (A	lame of	Date		Oc. Location -			
Saltimor			Burial 2 Cremation 3 Donation 5 Other (Specification)		Sale	in Ceme	tery 1	1-11:	06 M	lontab	merc	am.	
g	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Licer	0	01-0	- man 11	and Address of Facility		old Co			h's	
_	402 40		23a. Part1. = ler the di le se, or com	CLOUNTIN	UPS	SIGNUK	Funcion	me P.F	भ साल	H City	J. Fuc		3_
	<b>D</b>		shock, or heart failure. List only tmmediate Cause (Final				ode of dying, such as	Cardiac or R	espiratory arres	st,		Approximate Interval Between Onset and Deat	
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a c		PHALY					-		
	Examiner		Sequentially list conditions	b									
	be sit	Examiner	Sequentiatly list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a c	onsequenc	ce of):							
	be executed ician and burial-transit	хап	that initiated events resulting in death) Last	cDue to (or as a c	onsequenc	ce of):	·						
2/00	ate be executed thysician and the burial-transit	cal		d									
õ	certificate Iding phys	70	IF FEMALE:							1			
POX		Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal dea					23d. Date Mor	of delive	ry Day Year	
	0 0 0	yslc	1 Yes 2 No 9 Unknown	4☐ Pregnant at tim 9☐ Unknown	e of death	5 Other (	specify)					ou, car	
7	requires that the een signed by th hould be detache	by Ph	Part II. Other significant conditions of	ontributing to death but n	ot resulting	g in the underlying	cause given in Part I.		23e. Did toba	cco use contri	ibute to th	e cause of death	1?
cords	w requires been sig should by								1 🗆 Yes	2 No	3 🗌 Prob	ably 4 ∐Unkn	own
ပိ	aw as b 2 sl	Completed							24a. Was an autopsy	24b. W	ere autor	sy findings avail	iable
	Th ate pag	Con							performe	od? d No 1	eath?	2□ No	0.
VIII	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital: 💥					Check only one)				
5	Phys arthis aral dia	7: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury	285	Outpatient 3 [] [	OOA Other: 4 Nur 28c. Injury at Work?		5 Resident  Describe how			)	_
VISION	ath. rr: After	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	ear)	Injury M	Work? 1 ☐ Yes 2 ☐ N	No					
<u> </u>	or Atterdenter de irecton by the	ertification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	- At home, Specify)	, farm, street, facto	ory, office	28f.	Location (Stre	et and Numbe State)	or or Rura	Route Number,	
ב	pital o	O	One Continue Al Continue Di	Table to A									
	To the Hospital or Attending within 24 hours after death. To the Funerat Director: After completely filled in by the fune	edical	29a. Certifier  (Check only one)  Certifying Ph 2 Medical Exam	ysicien: To the best of n niner: On the basis of ex and manner stated	amination	and/or investigation	d at the time, date and in, in my opinion, deat	d place, and th occurred a	due to the cau at the time, date	se(s) and mar e and place, a	nner as sta nd due to	ited. the cause(s)	
	To the within To the compl	Me	29b. Signature and title of pertifier			2	9c. License number		290	I. Date signed	(Month, L	Day, Year)	
			Arbaar	W5			D 58033	3		11/06	1200	06	
1	T		30. Name and address of person who	completed cause of deat	h (Item 23a	a) (Type, Print)	NTER DRI		)				
_	-610	to.	31. Date filed (Month, Day, Year)	32/Registrar's			WIER DRI	UE, K	COCKUIL	LE, M	ARYL	AND 208.	50
	Sta Registr		MOV 1 3 20	06 /	No.	Come it	9						

06-08255 Johnathan Savage

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

			1- For State Registrar		ertificate o		—	7.5	eg. No 20	06	3572
Med	Physicia ical Exami		1. Decedent's Name (First, Middle,La Johnathan Say					2. Date of Deal	Day Year		e of Death 21 hrs
gar.			4a. Facility Name (if not institution, gi	4,0			or Location of Dea	October 3	4c. County of D	eath,	
	Funeral		Johns Hopkins Hospital  5. Social Security Number 6. 8	Sev 7 Age (In vir	s. last birthday)	Baltimore  If Under 1 Y		les la Data of Die	th(MM/DD/YYYY) 9	n/a	10.
	Director			M 2 F	3.5 Yrs	Months D		lin. 1/22		Country)	MD
	any.	}	Usual Residence of Decedent  10a State 10b County	10c. C	City, Town or Locat	ion				10d Ir	nside City Limits
	<u>*</u> .	ě	MD n/a		Baltimo	re					Yes 2 No
	Baltimore, MD 21215-0036  permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens Innportant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 823 E.41st Str	eet		10f. Zip Code 212	18	10	0g Citizen of What 0	Country? A	
	ath with tems 23 st be no	Funeral	11. Marital Status  1 X Never Married 2 Marrie	12. Was Decedent Ever in Armed Forces?	n U.S 13. Wa	as Decedent of I es, specify Cub	Hispanic Origin? ( an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	- 14. Race - Ar White, et		ıan, Black,
	ıfter des II", or i	by Fu		1 Yes 2 No		Yes 2 X	No specify:		Afr Specify: A	ican	-
	hours a		15. Decedent's Education (Specify of Elementary/Secondary (0-12)	only highest grade completed		nt's Usual Occup	pation (Give kind o	of work done	TOD. KING OF BUSINE	ess/industry	-
	5-0036 Led within 72 Hygiene other than *	Completed	12th	College (1-4 or 5+)	Janit	or			waste	папа	gement
	15-0 filed will Hygie d other	4	17. Father's Name (First, Middle, Las				1	ne (First, Middle, M	,		
	D 21215-00; should be filed with and Mental Hygiene 7 is marked other th natic event, the Men	To Be	Joseph Savage  19a Informant's Name/Relationship (	Type, Print )	19b. Mailing	g Address (Str	eet and Number o	Mae Sir	nber, City or Town, S	tate, Zip Co	ode) 04 0 0 7
į	Baltimore, MD 21215-0036 ermi, Pages I and 2 should be filed within 7 Department of Health and Mental Hygiera Important: If tiem 27 is marked other than injury or other traumatic event, the <u>Medica</u>		Joseph Savage  19a Informant's Name/Relationship ( Shontel L. John  20a Method of Disposition	nson/Childre	51 513	LUL D,	rataps	SCO AVE.	, Koseu	are,	MD
	nore, Mages land 2 nt of Health nt: If item 2 other traum		1 X Burial 2 Cremation 3	Removal from State	b. Place of Dispos crematory or of ing Mem	her place)		Date /6/06	20c. Location - City Woodlaw		
;	Baltim permit Pag Department Important: injury or ot		Donation 5 Other Specify 21. Signature of Funeral Service Lice	·					H F.A.		
			Tremerles (p	ues	92	00 Lib	erty RI	., Rand	dallstow	n, Ml	D 21133
	Physician /Medical		23a. Part I. Enter the disease, or comfailure. List only one cause on e	plications that caused the de each line. Multiple Gunshot Wo		ne mode of dyin	ig, such as cardiac	or respiratory arre	est, shock, or heart		oximate Interval veen Onset and Death
	≒xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence						_	
	.	Je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequenc	e of):					_	
		Examine	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	e of):					- M	
	760, icate be executed g physician and the burial - transit										
:	760, icate be ex g physician the burial	/Medical	UNPENDED  IF FEMALE:	AMENDED  23c. If yes, outcome of p.	rognoneu				Local Patrick Live		
	6876 certificate iding physe as the		23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fe	tal death 3	Ectopic preg	nancy	23d Date of deli	Day	Year
	Box 68 e death certiff the attending ed for use as 1	Physiciar	1 Yes 2 No 9 Unknow	9 Unknown	3 Ot	her (Specify)					
(	ires that the signed by a lbe detached	by Pi	Part II. Other significant conditions	contributing to death but no	ot resulting in the u	inderlying cause	given in Part I.		bacco use contribute		
	ords, I w requires is been sig should be	eted		·		_		- 24a Was a			ndings available
	ecor he law a te has b age 2 sh	Completed						autops perfor 1 ✓ Yes 2	med? death	1?	on of cause of
1	Vital Rec ysician: The his certificate director, page	Be Co	25. Was case referred to medical examiner?			26.Pla	ce of Death (Chec		Z NO I V	Yes	2 No
;	n of Vit ding Physic After this funeral dire	ျ	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2  28a Date of Injury	ER/Outpatient 28b. Time of I		Other Nurs		Residence 6 On	ther,	
	Division of Vital Records, P.O. tal or Attending Physician: The law requires that it is after death. After this certificate has been signed by led in by the funeral director, page 2 should be detactled in by the funeral director, page 2 should be detact.	Certification:	1 Natural 5 Pending	Oct 31, 2006	1945 hrs	· ·   _	Yes 2 V No	Subject shot			
	Divis pital or At ours after d eral Direct filled in by	rific	3 Suicide 6 Could no	t be 28e. Place of Injury - A		et, factory, office	building, etc.	28f. Location (S or Town, St	street and Number or tate)	Rural Rout	e Number, City
	Hospita 4 hours Funeral ely fille		4 Momicide	cian: To the best of my know		red at the time	date and place, ar		reet, Baltmore, Mo		
	Division of Vital Records, P.O. Box 68760, with 124 hours after the death certificate be executed within 24 hours after death. To the Inversal preference the former and preference. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Examine	er: On the basis of examination	n and/or investigat	tion, in my opini	on, death occurred	at the time, date a	and place, and due to	the cause	(s)
_		Ž	29b Signature and title of certifier	1/000	70 4	1	nse number C.M.E.		29d Date signed (	-	(Year)
	1		30. Name and address of person who	completed cause of death (I	tem 23a)		· . · ¥ 1 · bu ·		November 1, 2		
	3'			ant Medical Examiner		Street, Baltir	more, MD 212	01			
	Si Regis	tate trar	31. Date filed (Month, Day, Year)	32 Registrar's Sign	lature April	Me I					
				All .	- A						

## Please Type or Print in Black Indelible Ink

aurice N. Thon			nd <sup>S</sup> #20B <sup>f</sup> [	Jeryland G	Separ Cert	t <b>mpn376</b> ificate of	bleath ar Death	nd Ment	tal Hyg	iene Reg	. No.	200	6 3572
Physicia ledical Exami		Decedent's Name (First Maurice)		N			Thomas			Date of Death Month November :	Day 3. 2006	Year	3. Time of Death 2311 hrs
and the same of		4a. Facility Name (if not in Route # 4 @ She	_	et and number)		4	b. City, Town, o					ounty of Death	)
Funeral		Social Security Number		7. Age	(In yrs. las	st birthday)	If Under 1 Ye	ar If Unde		B. Date of Birth	(MM/DD/	YYYY) 9. Bir	thplace (State or
Director		218-96-7920	1 X M	2 F	25	Yrs.	Months Da	ys Hours	Min.	05–30	)-198	31 Foreig	ountry) Md.
any	ŀ	Usual Residence of Deced 10a. State 10b. C		1	0c. City, T	own or Location	on						10d. Inside City Limits
Maryland 28a-f show 1 at once.	Ę	Md.	NA			Baltim							1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 2019 Robb	Stroot				10f. Zip Code	.218		100	g. Citizen	of What Cou USA	ntry?
h with tems 23a	Funeral	11. Marital Status  1 X Never Married 2	12.	Was Decedent E Armed Forces?	ver in U.S		Decedent of Hes, specify Cuba				14	Race - Amer White, etc.	rican Indian, Black,
ter deat ", or ito er must		3 Widowed 4	Divorced If Yes	Yes 2 X	No		Yes 2 X N			,	Spe		lack
hours at natural Examin	eted by	15. Decedent's Education	n (Specify only hig	hest grade comp		16a. Decedent	t's Usual Occup	ation (Give			16b. Kind	of Business/	Industry
336 thin 72 re than "	nplet	Elementary/Secondary  12th grade	(0-12)	College (1-4 or 5+	•)	Ca	ashier				Fam	ily Do	llar
21215-0036  uld be filed within 7  Mental Hygiene marked other than c event, the Medica	$\sim$ 1	17. Father's Name (First, I	Middle, Last)		John	aon			s Name (Fi	rst, Middle, Ma	aiden Sur	name) Thom	
212 ould be I Menta i marke	To Be	Roland 19a. Informant's Name/Re	lationship (Type, F		JOH	19b. Mailing	Address (Stre	L eet and Num	nber or Rura	al Route Numb		r Town, State	e, Zip Code)
MD and 2 shue ealth and raumat		Helen Tho 20a Method of Disposition		Grandmot			Robb S			ltimor			218
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		1 X Burial 2 Cre 4 Degation 5 Of	mation 3 R	emoval from State		intry of Co	eaetery			.1-06	Dun Ran	dalk, dallst	Md wn, Md.
Balti Departit Importa Injury o	1	21. gnat e of Funeral S	ervice Licensee	1 /2 Ptr.	. 1		ame and Addre	-	Mar	ch F.H			21202
Physician	$\dashv$	23a Part . Enter the disea fail re. List only one			ne gelyh. i		101 E. I						Approximate Interval Between Onset and
/Medical Examiner	ì	Im hed te Cause (Final dor condition resulting in do	isease a Mult	i <b>ple Injuries</b> o (or as a consec									Death
مدين		Sequentially list condition	s, b										
	Examiner	if any, leading to immedia cause. Enter Underlying (Linear or injury that init	Cause c.	o (or as a consec									
uted Id ransit	Exa	events resulting in death)		o (or as a consec	uence of)	(							
), be exec sician ar urial - ti	Medical	UNPENDED	_ AM	ENDED	•								
18760, riffcate b mg physic as the bur	an/Me	IF FEMALE; 23b. Was decedent pregna past 12 months?		Live birth	e of pregn	,	tal death 3	Ectopio	c pregnancy	1		ate of deliver onth	y Day Year
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transi	Physician/I	1 Yes 2 No 9	Unknown 9	Pregnant at ti Unknown	me of dea	th 5 Ot	her (Specify)						
<b>∵</b> + <b>∑</b>	by Ph	Part II. Other significant	conditions cont	ributing to death	but not re	sulting in the u	inderlying cause	given in Pa	art I.				the cause of death?
ds, P.C equires that een signed ould be deta	ted k									24a. Was a	2 <b>V</b> N		bably 4 Unknown utopsy findings available
Records, The law requir cate has been s	Completed									autops perform 1 Ves 2	ned?	prior to death?	completion of cause of es 2 No
Vital Reorgician: The his certificate director, page	Be C	25. Was case referred to examiner?					26.Pla	ce of Death	(Check only				55 2 10
n of Viv ding Physid After this	ပ	1 Yes 2 1		28a. Date of Injur	v 1	ER/Outpatient 28b. Time of I		Other <sub>4</sub>	Nursing F	dome 5 F		6 ✓ Othe	r: Scene
ion C tending eath. tor: Af	ation	1 Natural 5 2 ✓ Accident	Pending Investigation	Nov 3, 2006	ar)	2259 hrs	1	Yes 2	. IPe	edestrian s			
Division of Vital Records, Hospital or Attending Physician: The law require 4 hours after death. Funeral Director: After this certificate has been si tely filled in by the funeral director, page 2 should b	Certification:	3 Suicide 6		28e. Place of Inju	-		•	building, et	1	or Town, Sta	ate)		ural Route Number, City
Hospit 24 hour Funer?		4 Homicide  29a ertifier (Check by 1 Certif	ying Physician: 3					date and pla	-		_	-	
To the Hos within 24 h	Medical			the basis of exam manner stated	ination an	nd/or investiga		on, death oc	ccurred at th	ne time, date a			ne cause(s)
		100	la On	enl				C.M.E.				nber 4, 20	
		me and address of			•	•	Charle D.	linner- 1	ID 04004				
	tate	Laron Locke MD 31. Date filed (Month, Day		Medical Exa 32. Registrar		re 🔌	Street, Bal	umore, M	LD 21201				
Regis			1 3 2006	SE WALAS.		. Apr	Mi)						

			For State Registrar	State of Maryland /		nt of Health and I te of Death	Mental Hygiei Reg.	4000	35729
	Physici	an	1. Decedent's Name (First, Middle, Last	) V . O.V . T	00	70	2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give	street and number)	4b. City	, Town, or Location of Death	Novembe	4c. County of Death	12:20 PM
	LAdillii		Sinai Hospita	1 of Baltimo		altrmore		^	I/A
	Funeral Director		×18-60-3138	7. Age (In yrs. last	7 Yrs. If Under Months	or 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Ye JUNE 15,	9. Birth Cour 1954 MA	place (State or Foreign ntry) RYLAND
	yland		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location		,		10d. Inside City Limits
	Ba-feb	ctor	MARYLAND N.	IA	B	ALTIMOR	E CITY	/	1,⊠Yes 2 No
	with the a or 2	Dire	10e. Styleet and Number  4521 MAAIA	RVIEW ROA	1	p Code	10g.	Citizen of What Cour	ntry?
	death me 23	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S.		edent of Hispanic Origin? (Secrify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Americ	
5-0036	72 hours after death with the Maryland nature!; or iteme 23a or 28a-f ehow idical Examiner must be notified at	by	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates:	1 ☐ Yes		o Hican, etc.)	Black, White,	etc. ACK
		letec	15. Decedent's Ed (Specify only highest grad	Joation 1 de completed)	6a. Decedent's Usu (Give kind of w life. DO NOT I	ork done during most of wor	rking 16b	o. Kind of Business/In	dustry
2121	s within piene. r than	Completed	Elementary/Secondary (0-12)	2 1/RS	~	ITIONAL SEA	RVICES 1	1D CORR	ECTIONS
	s 1 and 2 should be filed within f Health and Mantal Hygiene. Item 27 Ie marked other than ' other treumatic event, the Ma	BeC	17. Father's Name (First, Middle, Last)	7/3-	/ (/ ( (		ne (First, Middle, Maio		,
Maryland	should but Ment	2	CLAUDE K	IRK TOP	P SR	ROS	E LEE	<i>To</i>	NES
Ma	nd 2 shallth and 27 le m		19a. Informant's Name/Relationship (7	N TOPP (WIFE)	453/	S (Street and Number or Ru	IRD BA	ty or lown, State, Zip	10,21229
ore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	20b. Place	e of Disposition (Na etery, crematory or	ime of other place)	Date 200	. Location - City or To	
Baltimore	permit. Pages Department of Important: If it any injury or o		4 □ Donation 5 □ Other (Specify	) AR	BUTUS	CEMETERY 11-	13-06 B	ALTIHORE	MARYLAND
Bal	permit. Departi Importi any inj		21. Signature of Runeral Service Does	140m	394	ON FULTO	BROWN - NAVE. B	ALTO, MI	RALIHOME D. 21217
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the death. Done cause on each line.	Do not enter the mo	de of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Anoxic  Due to (or as a consequent	Brain	Injurg			5 days
1	Examiner		Consentially list and divine	Gastric (	by puss	Surgery			6 days
	sit and	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a consequent	- 1 -	. 1 -			10 11 110
	and all-tran	Examiner	that initiated events resulting in death) Last	c. //Orbid	nce of):	ity			10 years
68760,	icate be executed physician and s the burial-transit	edical E	(	d					
	- 9		IF FEMALE:	00-16					
P.O. Box	The law requires thet the death certif ste hes been signed by the attending bage 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	eath 3 Ectopic p			23d. Date of delive Month	ery Day Year
	res thet signed by	by Pr	Part II. Other significant conditions co	entributing to death but not resulting	ng in the underlying	cause given in Part I.	23e. Did tobac	co use contribute to t	the cause of death?
of Vital Records,	w require been sign						1 Yes	2 No 3 Prot	bably 4 Unknown
3ec	hes by	Completed					24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
tal		ပိ	25. Was case referred to medical			26 Place of Dec	1 Yes 2 □		2 No
<u></u>	g .s . <u>e</u>	To B	examiner?	Hospital: 1 Dinpatient 2 ER	VOutpatient 3 D	Other	lome 5 Residence	e 6 ☐Other (Speci	fy)
ion o	or Attending Pritter death. Director: After thin by the funeral		27. Manney of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Bb. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how i	injury occurred	
Division	s after death s after death el Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, facto	ry, office	28f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knowle iner: On the basis of examination and manner stated.	edge, death occurred a and/or investigation	d at the time, date and place n, in my opinion, death occu	a, and due to the caus urred at the time, date	e(s) and manner as s and place, and due t	stated. o the cause(s)
	To the comp	Σ	29b. Signature and title of certifier	0	29	c. License number		Date signed (Month,	Day, Year)
,	2		Rhinda Jule	y mo		D 28855	1	1/8/06	
6	1		30. Name and address of person who of DR RHONDA F			BEIVENEOR	AVE BAI	TO MO O	1215
	Sta		31. Date filed (Month, Day, Year)	2006 32. Registrar's Signature	& Spar	W.	14610116		
	Regist	eli	INO A T S	TOOL STORY	9				

Claude Toff

06-08403 Daylin A Taylor

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

<b></b> ,		1- For State Registrar	ertificate of		id Wichtai i i	_	eg. No.	0.530
Physicia Medical Eveni	in/	Decedent's Name (First, Middle, Last)				2. Date of Dea Month Novembe		3 Time of Death / 5
Medical Exami	ner	Daylin A. Taylor  4a. Facility Name (if not institution, give street and number)		h City Town o	r Location of Death		r 6, 2006 4c. County of Dea	
T'		Johns Hopkins Hospital		Baltimore	Location of Death	•	40. County of Dea	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs	last birthday)	If Under 1 Yes		_	rth (MM/DD/YYYY) 9. B	
Director		213-77-0721 1 XM 2 F	Yrs.	Months Day	ys Hours Min	09/10	/2006 Fore	Country) Maryland
any	ł		ty, Town or Location	on				10d. Inside City Limits
Maryland 28a-f show any 1 at once,	ē		altimore					1 XYes 2 No
ith the Maryland 23a or 28a-f sho notified at once,	rector	10e. Street and Number		10f. Zip Code		į.	0g. Citizen of What Co	
72 hours after death with the Maryland n "natural". or items 23a or 28a-f she al Examiner must be notified at once	al Dir	611 N. Highland Avenue  11. Marital Status  12. Was Decedent Ever in least 1	U.S. 13. Was	21205	ispanic Origin? ( S		United Stat	erican Indian, Black,
Baltimore, MD 21215-0036  permit Pages I and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner must be	nuel	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Ye		an, Mexican, Puerto		White, etc.	STOOT ITTOON,
after o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1	Yes 2 X No				Lack
hours natur	ted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)			ation (Give kind of v e. DO NOT use reti		16b. Kind of Business	s/Industry
336 thin 72 re than	Completed	0	Never	Worked			N/A	
5-0( led wi Hygier the M		17. Father's Name (First, Middle, Last)	1.0.02	11023100		, ,	Maiden Surname)	
121 d be fi lental arked	o Be	Damon A. Taylor  19a. Informant's Name/Relationship (Type, Print)	LAGE MARIES	Address (O)	Okeecha		wn mber, City or Town, Sta	
MD 21215-0036 tod 2 should be filed within 7 that and Mental Hygiene m 27 is marked other than aumatic event, the Medica	ř	Okeecha Brown / Mother		,				,
more, MD 21215-0036 Pages 1 and 2 should be filed within ent of Health and Mental Hygene nt: If item 27 is marked other tha rother traumatic event, the Medic		20a. Method of Disposition 20b	D. Place of Disposition of the crematory or oth	tion (Name of ce	emetery,	Date	20c. Location - City of	r Town, State
MOF Pages ent of int: If	П	1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Qther Specify:			netery 11	/11/200	Woodlawn,	, Maryland
Baltimore, bermit Pages I ar Department of Hee Important: If ite	A	21. Sign ture of Funer I e lice Licensee	22. Na	ame and Addres	ss of Facility Da	vid J. V	Weber Funer	cal Homes PA
	Ì	23a. Part I. Enter the 11st ase, or complications that caused the deal						ryland 21231 Approximate Interval
Physician /Medical		failure List only one cause on each line.				in reapplicatory and	oot, onook, or near	Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Sudden unexplaid  Due to (or as a consequence		ш шшак	. <u>y</u>			1
	_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence	of):					+
	mine	cause. Enter Underlying Cause (Disease or injury that initiated						
ted Insit	Examine	events resulting in death) Last Due to (or as a consequence	of):					
760, from the executed g physician and the burial - transit	Medical	X UNPENDED = d AMENDED #23a,27	,28a-f, pe	rME, g862	., 12/14/06	TT		
760, ficate be a physicia the buria		IF FEMALE: 23c. If yes, outcome of pre	egnancy				23d Date of delive	
x 68. h certifi	ician	past 12 months?  4 Pregnant at time of company and the pregnant at the pregnant at the	dooth	al death 3 ner (Specify)	Ectopic pregna	ancy	Month	Day Year
Box ne death c the atten	Physic	1 Yes 2 No 9 Unknown 9 Unknown				_		
of Vital Records, P.O. Box 68' ing Physician: The law requires that the death certificate has been signed by the attending timeral director, page 2 should be detached for use as	ð	Part II. Other significant conditions contributing to death but not	t resulting in the u	nderlying cause	given in Part I.		obacco use contribute t	o the cause of death?  obably 4 V Unknown
ds, equires een sig	ompleted	-				24a. Was	an 24b. Were a	autopsy findings available
e law r e has b ge 2 sh	mple						rmed? death?	
II Re	O	25. Was case referred to medical		26.Plac	ce of Death (Check	1 Yes	2 No 1 V	Yes 2 No
ision of Vital   Attending Physician: r death. retor: After this certif by the funeral director.	o Be	examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2	✓ ER/Outpatient	3 DOA	Other Nursin	ng Home 5	Residence 6 Oth	er:
	Dn: T	27. Manner of Death  1 Natural 5 Paneling (Month, Day, Year)	28b. Time of Ir		ury at Work?	28d. Describe	how injury occurred	
ivisior or Attend after death Director:	cati	Pending Accident Pending Pending Prod 11/6/2006 Prod 11/6/2006 Prod 11/6/2006		am	Yes 2 No	unknowi		Pural Pouta Number City
≥ P 등 P i	ertification:	3 Suicide 6X Could not be determined (Specify) reside		it, ractory, office	bunding, etc.	or Town, S	State) 611 N. H	Rural Route Number, City ighland Avenue
Di the Hospital hin 24 hours of the Funeral	O	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge)		red at the time, o	date and place, and			arted.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and manner stated	n and/or investigati			at the time, date		and the state of t
	Σ	29b. Signature and title of certifier	) ~		se number		29d. Date signed (M	
OHA!		and Hall	- de	_ 0.0	IVI. L.	-	November 6, 20	000
di		Name and address of person who completed cause of death (Ite Carol Allan, MD Assistant Medical Examiner		Street, Baltin	nore, MD 2120	)1		
	ate	31. Date filed (Month, Day, Year) 32 Registrar's Signa	ature 2004	1 J				
Regis	rar	NOV 1 3 2006	3. Wallet	LOES NO.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 200<sup>Vear</sup> Imogene B. Tipton 12:00 pm 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death National Lutheran Home Rockville Montgomery If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth 08–12–1928 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months 1 ☐ M 2XX F 420-34-4954 Alabama 78 Yrs Usual Residence of Decedent 0a. State 10c. City, Town or Location Bethesda 10b. County 10d. inside City Limits Maryland Montgomery 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6704 Tulip Hill Terrace 20816 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White Specify: 31 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry elementary/Secondary (0-12) College (1-4or 5+) Bookeeper Accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First Middle, Last) John Cefus Burroughs Fanny Dura Merrill 19a. informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane T. Bradt 6704 Tulip Hill Terrace, Bethesda, Maryland 20816 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 M Other (Specify)Entombment Shadowlawn Mausoleum 11/11/2006 LaGrange, Georgia 22. Name and Address of Facility Hubbard Funeral Home, Inc. Signati Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1-8 0515 Due to (or as a consequence of): Infection INa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Vear 4☐Pregnant at time of death 5 Other (specify) Yes 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? disorder 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Dementica 24a. Was an autopsy performed 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturai Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

The law requires that the death certificate be executed physician and s the burial-transit Division or Vital Records, P.O. Box 68760, as attending nse Por ed by the a signed by be det page 2 s has certificate director, this funeral o After or Attending or . s after dea. ral Director: A filled in

Physician

/Medical

Examiner

**Funeral** 

Director

a or 28a-f sh

r than "natural", or items 23a the Medical Examiner must b

marked other traumatic event,

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any Injury or other traumatic event

Important: If any Injury or once,

**Physician** 

Examiner

/Medical

Director

Funeral

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Certification:

Medical

29b. Signature and title of certifier

SAMUEL

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

within 24 hours a

State

31. Date filed (Month, Day, Year) Registrar DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6.

MALLER

32. Registrar's Signature

MO

29c. License number 00506

Veirs Drive Rockville Maryland 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene perlnf, G861,I1/17/06 Certificate of Death

Reg. Not. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** Yoshiko Taniuchi November 9, 2006 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4825 Montgomery Lane Bethesda Montgomery If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 👿 F Yrs. Director 579-90<del>-</del>7118 76 January 16, 1930 Japan Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other then "natural", or Items 23a or 28a-f show eny Injury or other traumattc event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Funeral Director Maryland Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4825 Montgomery Lane 20814 United States Race - American Ind Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify. 3 Widowed 4 Divorced Asian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (*First, Middle, Last*) æ Asao <del>Tsuri</del> ို Michyo Hanakawa 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hiroshi Taniuchi/Husband 4825 Montgomery Lane, Bethesda, Maryland 20814
Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State November 11, 2006 Parklawn Memorial Park 11, 2006 Rockville, Maryland

22 Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue

M00803 Bethesda, Maryland 20814-3501 4 ☐ Donation 5 ☐ Other (Specify) ral Service Licen 21. Signature o 2 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Advanced Pancreatic Cancer 1.5 Years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit and resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 🛛 No 9□Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ filled in by the funeral director, page 2 should be Possible Bowel Obstruction 1 ☐ Yes 2 🗌 No 3 Probably 4 ∭Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2**X** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) 1 ☐ Yes 21 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 detailed Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ို D0064115 November 10, 2006

State Registrar

DHMH 17 Rev 1/2001

30. Name and address derson who completed cause of death (Item 23a) (Type, Print)

.D.

32. Registrar's Signature

Kelly W. Mercer,

31. Date filed (Month, Day, Year)

9707 Medical Center Drive, #300, Rockville, Maryland 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Viola Urbach  $A^M$ 11, 2006 8:35 November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson <u>Gilchrist Center</u> If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 21,1911 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sex **Funeral** Days Hours 1 □ M 2 🖸 F 213-72-5621 95 Maryland Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 1 □ Yes 2\ No Funeral Director Maryland Dundalk Baltimore 10g. Citizen of What Country? 10e Street and Number 10f. Zin Code 21222 USA 1106 Dundalk Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: White δ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7 Is marked other tha traumatic event, the 12 years Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Margaret Elizabeth Schissler William Henry Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a lant: If Item 27 is jury or other trains 8178 North Boundary Road, Dundalk, Maryland 21222 John Denny Urbach son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition November 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once, Dundalk, Maryland Sacred Heart of Jesus Cem. 15, 2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Maryland 21222 23a. Part1 Ender the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** JNG Cancel /Medical Due to (or as a or nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease of injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Year Month Day 4□Pregnant at time of death 5 ☐ Other (specify) o 9□Unknown 9 Unknown signed by t. d be detach ٦ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was ...
autopsy
performed?
Yes 2 1 10 No cate has ; certificate Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) NUS (( 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA P After this 27. Manner of Death funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Injury at Work? Certification: Attending 5 Pending Injury 1 ☐ Yes 2 ☐ No To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) anems November 11 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) harlest Tayson my 21204 6565

DHMH 17 Rev 1/2001

State Registrar

Amon 31. Date filed (Month, Day, Year)

NOV 1 3

2005

Baltimore, Maryland 21215-0036

**Physician** 

/Medical

**Examiner** 

Division or Vital Records, P.O. Box 68760,

Funeral Director	3-7*	5. Social Security Number 228-10-9914	6. Sex 11X M 2□F	ge (In yrs. last bii 88		nder 1 Year oths Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 1 2 / 1 4	/ 1917	9. Birthplace (State or Foreign Country) VIRGINIA
Maryland a-f show filed at	tor	Usual Residence of Decedent  10a. State 10b. County  MD N/		10c. City, Tow		E CIT	Y			10d. Inside City Limits 1 X Yes 2 ☐ No
death with the Maryland ms 23a or 28a-f show rmust be notified at	Funeral Director	10e. Street and Number 1561 E. BEL	VEDERE AVE	, APT.	417	f. Zip Code 212	39		10g. Citizen of US	What Country?
after or Ite	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Marr  3 ☐ Widowed 4 ☐ Divorced	If Yes Give	? No		Decedent of Hi , specify Cuba es 2 <b>X</b> No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Ra Bl: Spec	ace - American Indian, ack, White, etc. BLACK
within 72 hours iene. than "natural", the Medical Exa	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12) 1 2 T H	nt's Education st grade completed)  College (1-4or	F.\\	(Give kind o	Usual Occupa of work done of OT use retired PERAT	turing most of work )	king	SHAW	Business/Industry BUS SPORTATION CO.
uld be filed wit Aental Hygiene rked other tha tic event, the	To Be C	17. Father's Name (First, Middle, WILLIAM C.		- '			18. Mother's Nam	e (First, Middle, TA JOH		ame)
and 2 shows alth and Market A 127 is mader trauma		19a. Informant's Name/Relations CHARLES W. W			. Mailing Add	ress (Street a	OAKS R	nal Route Number	er, City or Town ESVILI	n, State, Zip Code) LE, MD 21208
Pages 1 an ment of Heal ant: If Item 2 ury or other		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (5		20b. Place o cemete ARBU	f Disposition ery, crematory TUS M	(Name of v or other plac EM • P	e) ARK 11/	Date 13/06		- City or Town, State
permit. Departr Importa any Injk		21. Signature of Funeral Service	Licensee	Xava		ne and Addres				RAL HOME 21207 BALTIMORE, MD
Physician /Medical Examiner		23a. Pany Enter the disease of shoot or in trailure. List Immediat Onches (Final disease) andition resulting death)	r complications that cause t only one cause on each l aa	d the death Do ine. Olable s a consequence	m	mode of dyin	g, such as cardiac	or respiratory ar	Fren	Approximate Interval Between Onset and Death Www.least
be executed ician and burial-transit	ical Examiner	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	se se	s a consequence	mea	\$ a	y hy spirat	ion - s	lung	filrosis
the death certificate y the attending phys ched for use as the	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e pf pregnancy 2 ☐ Fetal death at time of death		pic pregnancy er (specify)			- 1	ate of delivery Month Day Year
requires that the een signed by th rould be detache	ted by Pr	Part II. Other significant conditi	ons contributing to death	but not resulting i	n the underly	ing cause give	en in Part I.		_	ntribute to the cause of death?  3 Probably 4 Unknown
The law ate has be page 2 sh	Complete	D-aletes GERD								. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
Iclan; Sertific ector,	Be	25. Was case referred to medica examiner?	Hospital:				26. Place of Deat			-
Phys this	L L	1 ☐ Yes 2 ☑ No  27. Manner of Death	1 ☐ Inpat	ient 2 ER/Oı	utpatient 3[ Time of	DOA Othe	4 □ Nursing H	ome 5 Resid		
or Attending Physician: after death. Director: After this certific in by the funeral director,	Certification:	1 Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could	ng (Month, Di gation	ay Year)	Injury M		Yat (? Yes 2 □ No	28d. Describe h		
ne Hospital or Attendi n 24 hours after death. ne Funeral Director: A pletely filled in by the fu		4 ☐ Homicide determ	nined 28e. Place of it building, e	jury - At home, fa tc. <i>(Specify)</i>				City or Tou	vn, State)	nber or Rural Route Number,
To the Hospital within 24 hours a To the Funeral i completely filled	Medical	one) 2 Medical	ng Physician: To the bes Examiner: On the basis and manner s	of examination ar	e, death occu nd/or investig	ation, in my o	pinion, death occu	rred at the time,	date and place	e, and due to the cause(s)
O North	2	29b. Signature and tipe of certified	ind Stei	ner		29c. License				ed (Month, Day, Year) - 9 - 6
		30. Name and address of person	who completed cause of		(Type, Print)	Loch	Paves	Rlvd	/ Ra	-9-6 160 MD 21239

State Registrar 31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician SEAA AUBREY WILLIAMSON 7:20 OV /Medical 4a. Facility Name (If not institution, give street and number)
3973 BAYSIDE DRIVE 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNEARUNDEL EDGEWATER If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 214-62-0745 18 M 2□ F 5 Director -15 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28e-f ehow is 1 end 2 should be filed within 72 hours after death with the Marylar of Heelth end Mentel Hygiene.
Item 27 Ie marked other then "naturel", or Iteme 23a or 23e-f ehov other treumatic event, the Medical Examinar must be inclined at 1 Yes 2 No DREWATER Directo anne Arundel 10e. Street and Number 10g. Citizen of Whal Country? 2103 . S. A SIDE DR. Race - American Indian, Black, White, elc. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: WhITE þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DERINTENDENT STEEL CONSTRUCTION 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame, Be SEBAA. Williamson SR. TNNA Peges 1 end 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3973 Bayk DE DE. EDGEWATER, MD. 21037 GIRLFRIEND Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Peges 1
Department of IImportant: If its
eny injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature Funera Perv Licensee 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 23a Part : Enter the disease, or complications that passed the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Years Cancel /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical use es ettending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. signed by the e d be deteched f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 Yes 2 No 3 Probably 4 Unknown certificete has been si rector, pege 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 2 No 1 ☐ Yes Division of Vital director 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes Z No Other: 4 Nursing Home Residence 6 Other (Specify) ဥ 1 Inpalient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Dale of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Injury 5 Pending 1 ☐ Yes 2 ☐ No deeth. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funerel [ Contitying Physician: To the best of thy knowledge death occurred at the time date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Chack only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kanine Weins November 8, 2006 D52830 MP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Borgare Road #300 Annapolis MO 900 eanine Werner, mp 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav JEBBER Year Month **Physician** (A) 18. 2006 6:15 PM October /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Takoma Park Sligo Creek Nursing Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 unk 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 € M 2 □ F Days Hours 68 Director Jan 23, 1938 578-48-5150 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or ttems 23a or 28a-f show any injury or other traumatic event, the Mydical Exam increment be routlised at once. 1 ☐ Yes 2√ No Director MD Prince George's Laure1 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 423 Old Line Avenue 20723 Funeral 12. Was Decedent Ever in U.Sunk
Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates:

1 ☐ Yes 2 ☒ No Specify: unk 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 Specify: white þ 3 Widowed 4 Divorced unk unk 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7525 Carroll Avenue Takoma Park, MD Sligo Creek Nursing Center 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State \* 4 □ Donation 5 X Other (Specify) in state 21. Signature of Funeral Service Sicensee State AAATOM So Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part i Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner ng physician and as the burial-transit The taw requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown signed by i 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown as been sig 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hasl autopsy page 1 ☐ Yes 2 ☐ No this certificate 1 ☐ Yes To the Hospital or Attanding Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient Other: 4X Nursing Home 1 ☐ Yes 2 No After this cr ို 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 1 D Natural 2 Accident 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury 5 Pending 1 🗌 Yes investigation within 24 hours after death To the Funaral Director: / completely filled in by the f Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier

Registrar

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Prin

MD 34 (5)

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

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	Physicia 'ical Exami			3. Time of Death Year 1227 hrs
				ounty of Death
			Sinai Hospital Baltimore	
	Funeral Director		1 M 2 K 86 Yrs. Months Days Hours Min. Oct 30, 192	(State or Foreign Country) 9. Birthplace (State or Foreign unk
	any	1	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	<b>*</b>	7	Baltimore	1 X Yes 2 No
	ith the Maryland 23a or 28a-f sho notified at once.	Director		n of What Country? USA
	MOCE, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with its Maryland ent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she rother traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married 2 No 14 Never Married 2 No 15 No 16 No 17 No 17 No 18 No 18 No 18 No 18 No 19 No 18 No 19 No	l. Race - American Indian, Black, White, etc.
	irs afte iiral", miner	2	3 Widowed 4 Divorced in test civil test of Dates:	d of Business/Industry unk
	imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours aftenent of Health and Mental Hyglene. Iant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examine	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) unk unk	To business/industry UTIK
	215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica			ımame) unk
	2121 ould be f Mental marked ic event,	o Be		or Town State Zin Code)
	MD and 2 shot alth and m 27 is aumatic		Sinai Hospital 2401 W. Belvedere Avenue Baltimo	. ,
	Baltimore, MD 21215-00; permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med			cation - City or Town, State
	Baltimore, permit. Pages I an Department of Hea Important: If iten		4 Dopation 5 A Other Specify, in state	
	Balt permit. Departi Import injury		21. Speature of Funeral Service Lydres Director  22. Name and Address of Facility State Anatomy Board 655 W. Ball Baltimore, MD 21201	timore Street
	Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, failure. List only one cause on each line.	Approximate Interval Between Onset and
	Examiner	9 15	Immediate cruse (Final disease or condition resulting in death)  a. Arteriosclerotic cardiovascular disease  Due to (or as a consequence of):	Death
		L	Sequentially list conditions, b	
		nine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated C	
	cuted nd ransit	l Examiner	events resulting in death) Last Due to (or as a consequence of):  d.	
	760, icate be executed physician and the burial - transit	Medical	UNPENDED AMENDED	
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	cian/	23b. Was decedent pregnant in the past 12 months?	Date of delivery onth Day Year
	BO) ne death the att	S	10 1 Ves 2 V No 9 Linknown	
	P.O.	by F	1 Tyes 2 N	e contribute to the cause of death?  No 3 Probably 4 V Unknown
	rds, require been si	Completed	24a. Was an	24b. Were autopsy findings available
	eco he law ate has	dwc	autopsy performed?	prior to completion of cause of death?  1 Yes 2 No
	al R inn: T certifica	še Č	25. Was case referred to medical     26.Place of Death (Check only one)	
	f Vit Physic er this c	To B	O 1 Yes 2 No Pospital 1 Inpatient 2 Y ER/Outpatient 3 DOA Outel 4 Nursing Home 5 Residence	
	on o inding ith. r: After	ion:	27. Manner of Death 28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury 28d. Describe how injury	occurred
	Visic or Atte fter des Directo in by th	ificat	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and County of State)	Number or Rural Route Number, City
	Dispital cours a neral I	Certification:	4 Homicide determined (Specify)	
	Division of Vital Records, P.O. Be To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached for	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and not one 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated.	
		Ž	7 . 00	te signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a)	per 31, 2006
			Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
	S Regis	tate	11011 4 0 0000	
	1/6915	416.1	MINING CHUM ANDROLD AF ANDROLD	

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 0 5 35738 1 - For Stete Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Dolores 2:14 2006 рм NOU /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5715 2nd Avenue Halethorpe
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Y June 12, **Funeral** 9. Birthplace (State or Foreign Year 1928 Maryland 1□M 2♀F 220-22-7054 78 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ir then "neturel", or Items 23a or 28a-f show the Modical Examiner must be rigitled at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5715 2nd Avenue by Funeral 21227 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2☐ No If Yes, Give A Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours ofter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 3 Widowed 4 □ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 end 2 should be filed to Depertment of Health and Mental Hygie Importent: If Item 27 is marked other til sny Injury or other traumatic event, IIII once. Clerk Mail Room 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ White George Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna J. Hayes (Daughter) 5715 2nd Avenue, Halethorpe, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore Crematory
Loudon Park 20a. Method of Disposition 20c. Location - City or Town, Slate 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/12/06 Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** carcinoma 2 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner anding physicien and use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ō Month Day Year 5 Other (specify) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No page 2 should Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 210 No 1 Yes or Attending Physicisn: rector, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient 20-No Other: 4 Nursing Home 5 Residence 6 Other (Specify) င္ 1 Tyes funeral dir 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28d. Describe how injury occurred 28c. Injury at Work? After Natural 5 Pending investigation death. М 1 ☐ Yes 2 ☐ No 2 Accident efter death 6 Could not be 3 ☐ Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide To the Hospital of within 24 hours of To the Funeral D completely filled it Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and tiple of certifies 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

GORMLE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUR BALTIMORIE MID 32. Registrar's Signature

D18587

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [ For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 4:55 PM 2006 George /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Randalktown,

If Under 1 Year If Under 24 Hrs.

Adonths Days Hours Min.

July 25,1928 Randallstown Center timore County 9109 Liberty Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 ☐ F Yrs. WashingonDC Director 73 577-34-7888 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Md. Baltimore Randlestown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9109 Liberty Rd. 21133 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No \$ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Mechanic Private Industr 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth eny liqury or other treumatic event <u>pres.</u> 18. Mother's Name (First, Middle, Maiden Surname) Be George August Josephine Armbruster 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12648 Council pak pr Waldorf Md. 20601
ce of Disposition (Name of Date 20c. Location - City or Town Sta Irma A. Hartman/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Riverdale Crematory 10/24/06 Riverdale, MD 21. Signatural Fineral Service Licensee 22. Name and Address of Facility Cedar Hill Funeral Home mo145 Pennsylvania Ave Suitland Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Preumonia **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 | Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 | Yes 2 | N Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 1 rsing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of beath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Zumural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Zertifying Physician: To the best of my knowledge, death undurind at the time, date and plane, and due to the causa(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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Baltimore, Maryland 21215-0036

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death.

To the Hospital of within 24 hours of To the Funerel D

or Attending Physicien: The law requires thet the death certificate be executed

Division of Vital Records, P.O. Box 68760

State Registrar

31. Date filed (Month, Day, Year) 2 4 2006 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

OCT 2 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 35741 State of Maryland / Department of Health and Mental Hygiene [] [] [ 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 10/26/2006 Year 8:15 A M Katherine Marie Billings 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Forest Glen Nursing Home Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex

/Medical Examiner

**Funeral** 

**Physician** 

Director r Items 23a or 28a-f show itner cust be netified at ō "natural",

filed within 72 hours after death with the Maryland other traumatic event, the Mudical Extension Hygiene. and Mental Hygi Pages 1 and 2 should be inent of Health and Mental Int; If item 27 Is marked o permit. Pages Department of Important: If it any injury or o

Baltimore, Maryland 21215-0036

**Physician** /Medical **Examiner** 

or Attending Physician: The law requires that the death certificate be executed burial-transit the attending physician and the been signed by certificate has director, page 2 this funeral After death. the

Division of Vital Records, P.O. Box 68760.

Completed by Funeral Be Examiner Physician/Medical þ Completed Be

after death. filled in by 24 hours a Funeral I completely

8. Date of Birth (Month, Day, Year) 09/19/1950 Birthplace (State or Foreign Country)
 DC Days Months Hours 1 ☐ M 2 🔀 F 56 577-68-2318 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 1 XYes 2 No Landover Prince Georges Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20785 U.S.A. 8942 Congress Place Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: Black Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Cashier 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Margret Clagget William Brewer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gerald Billings / Son 2834 Retnag Rd. Petersburg, Virginia 23805 20b. Place of Disposition (Name of cometery, crematory or other place)
Anatomy Gitt 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Hanover, Maryland 10/26/06 5 ☐ Other (Specify) ¹ 4 ⊠Donation Registry 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Taylor's Funeral Home 1722 N.Capitol St.NW Washington, DC 20002 2. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one lause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Cancer Breas Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Oriknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 1 🗆 Yes 2K) No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 🗷 ¥No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Lactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DOOS4166 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

OCT 26 2006

the within To the

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32. Registrar's Signature

Sunitua Bhogaville, 1220A East Juppa Road Suit 230, Toluson 4021286

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Continue of Death 35742 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Oct. 23, GEORGE M BURKS SR. 2006 6:15am M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Elderly World Landover If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1X□ M 2□ F Director July 18,1918 Virginia 230-03-0279 88 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23e or 28e-1 show unt; of items 23e or 28e-1 show unty or other traumatic event, The Medical English and the inclinited at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MXYes 2 □ No Director D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1209 W. St., N.W. 20009 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No Specify: Specify: Black ð lf Yes, Give Year or Dates: 3 € Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4th Laborer Governemnt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ernest Burks Susie Braddock 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Burks Jr./SOn 1233 Rock Creek Ford Rd, N.W. WDC 20011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 10/27/2006 Harmony Mem Pk. Landover, MD. 21. Signature of un in Gery Licensee 22. Name and Address of Facility Johnson & Jenkins Inc. 716 Kennedy St., N.W. WDC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition a. Advanced Sen:/e Demeny; 9. Approximate Interval Between Onset and Death Physician disease or condition resulting in death) Many yos. /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): 68760. Physiclan/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐ Pregnant at time of death P.O. I 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown s been signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by Diabetes, Limb Contractures 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Pressure somes, Hype-/1 pidemia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Heart Block. Portinson's Disease 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death | Check on one 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Hospitalce 6 Other (Specify) N After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Injury Medical Certification: 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) Y D D31001 rite, MD. Greenbelf, MD 20770 urkewit voit

State Registrar 31. Date filed (Month, Day, Year) OCT 2 5 2006 32, Registrar's Signature

06-08105 Dwayne O. Bragg

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 35743

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Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201			/ //	1 1			O.C.	M.E.		October 28	, 2006
Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201			30. Name and address of person	who completed cause of d	eath (Item 23	3a)	1				
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Registrar

State

Blown & Aporto

VENKAT S. RAMANAN, MD, 50 POST OFFICE RD., #304, WALDORF, MARYLAND 20602

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OCT 2 6 2006

32. Registrar's Signature

31. Date filed (Month, Day, Year)

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-52			23a. Par1. Enter the disease, or companion, or heart failure. List only	olications that caused one cause on each lin	the deat	h. Do not ente	er the mod	te of dying	, such as	cardiac o	r respiratory arr	est,			Approxim Interval B	etween
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Division of Vital Records,	\$ w 0	2	1  Yes 2  No  27. Manner of Death 1  Natural 5  Pending	Hospital: 1 Inpatier  28a. Date of Injur (Month, Day	v	ER/Outpatient 28b. Time of Injury	2	8c. Injury Work	at	2	ne 5 Reside			Specify	)	
Divisi	l or Attending after death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	ome, farm, stre	M 1 ☐ Yes 2 ☐ No  reet, factory, office 28f. Locat City of				8f. Location (St City or Town	ocation (Street and Number or Rural Route Number, rity or Town, State)						
_	To the Mospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one)  1 Certifying Phyone	rsician: To the best of iner: On the basis of and manner sta	examinai	wledge, death tion and/or inv	occurred estigation	at the time	o, date and nion, deat	i place, a	nd due to the ca	use(s) a ate and p	nd manne place, and	or as sta	ated. the cause	(s)
	To the To the Complet	Me	29b. Signature and title of certifier	)			290	. License				9d. Date	signed (A	fonth, E	Day, Year)	
	(n)		10:/	/ _				D	5 Y	18	20	tobe	18,	2006		
	(4)		30. Name and address of person who con Donald George	, M.D. 7525	Gree	nway Cen	ter Dr	rive S	uite 1	13 Gr	eenbelt,	Mary	and !	20770	0	
2.0	Sta Registr		31. Date filed (Month, Day, Year)  OCT 2 3 2006	32. Registra	r's Signal	Spen	2									

		-	For State Registrar	State of Mar	-	partmer ertificat			l Mental		ene 006	5	35746
H	Physici		1. Decedent's Name (First, Middle, Last) Kenneth	Phillip	p Bla	ansfie	ld			of Death th ober	24, 2008	ar O	3. Time of Death a 6:50 M
	/Medio Examin		4a. Facility Name (If not institution, give si 31994 Mt. Hermon Ro				Town, or l	ocation of De	ath		4c. County of D		
	Funeral Director		5. Social Security Number 221–03–8153 6. Sex 1 △	M 2□F 7. Age	(In yrs. last birthd	ay) If Unde Months	r 1 Year Days	If Under 24 H Hours Mi	n. (Mon	of Birth th, Day, 1	rear)	Count	ace (State or Foreign y) rland
	D	7.	Usual Residence of Decedent  10a. State 10b. County  Markyland Wincomic		10c. City, Town o								d. Inside City Limits 1 ☐ Yes 2 🎖 No
with the Mi	with the Man or 28s-f	i Director	Maryland Wicomics  10e. Street and Number  31994 Mt. Hermon 1		Salisbu	10f. Zi	Code 21804			109	g. Citizen of Wha	t Count	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23s or 28s-f show says injury or other traumatic event, the Medical Examinar must be indiffed at ODGs.	by Funeral	11. Marital Status 1 11 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		3. Was Dece If Yes, spe 1 \( \text{Yes}	cify Cuban	panic Origin? , Mexican, Pu Specify:	(Specify Yes erto Rican, et	or No-	14. Race - A Black, V Specify:	Vhite, e	
Maryland 21215-0036	within 72 hou ene. then "natura he Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		) (G	ecedent's Usu live kind of wi e. DO NOT u	ork done du	ion ring most of v	vorking		Sb. Kind of Busing		Enterprise
land 2	uld be filed Aental Hygi rked other tic event, I	To Be Co	17. Father's Name (First, Middle, Last)  Earl T. Blansfield						lame (First, A	diddle, Ma	aiden Sumame)	J.C.	<u> </u>
	ind 2 shou alth and N 27 Is ma sr trauma		19a. Informant's Name/Relationship (Type Earl T. Blansfield			-					City or Town, Star		•
altimore,	Pages 1 and the part: If item		20a. Method of Disposition  12 Burial 2 Cremation 3 Re  4 Donation 5 Other (Specify)	moval from State	East No.	ew Mar	me of other place Ket	10,	Date /27/06		oc. Location - City		
Balt	permit. Departr Imports eny inju		21. Signature of Funeral Service Logise	nozy (FSb	0	HOLLO	nd Address Way F OW Hi	uneral 11 Rd.	Home l	Profe sbury	essional 7, MD 218	Ass 304	sociation
0	Physician /Medical Examiner		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line	).			PNE		tory arres	st,		Approximate Interval Between Onset and Death YEAR
8760,	cate be executed physicien and the burial-transit	ai Examiner	Sequentially list conditions, any leading to a madritis cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  C. Due to (or as a consequence of):									
P.O. Box 687	The law requires that the death certificate ate has been signed by the attending physoage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	3 □Ectopic p 5 □ Other (s					23d. Date of delivery Month Day Year				
	w requires that been signed b should be deta	٥	Part II. Dther significant conditions con	ributing to death but	not resulting in th	e underlying	cause give	n in Part I.	23e	. Did toba	cco use contribu		cause of death?
of Vital Records,		Completed							-	. Was an autopsy performe	ed? prior	to com	sy findings available pletion of cause of
Vita	Physicien: The rist certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:				26. Place of D					
on of	× 5 €	ıtlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatien 28a. Date of Injury (Month, Day	t 2 ☐ ER/Outpa 28b. Tim Year) Inju	e of	28c. Injury Work	at			ce 6 Other (:	Specify	
Division	- 9 .= 6	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						ation (Stre or Town,	eet and Number o State)	r Rural	Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical (	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	ician: To the best of er: On the basis of e and manner state	examination and/o	eath occurred or investigation	at the time	e, date and pla nion, death or	ce, and due ccurred at the	to the cau	use(s) and manne e and place, and	r as sta due to	ited. the cause(s)
	Totl Totl Comp	ž	29b. Signature and title of certifier		-	29	c. License			29	d. Date signed (N	1	
,	Q MI		Polit all	, ,	7-0-		02	9168			10/2-6	10	6
	HOP.			M.D.	1346	5.	PIVIS	10N 9	57, 5	1-15	BUNY	MI	71804
8	Sta Regist		31. Date filed (Month, Day, Year) OCT 2 6 20	32. Segistrar	's Signature	Brask.	,		,		•		

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Chary Bosone		1- For State Registrar		e of Death	ind Menta		No. 20	06 3571
Physicia	an/	Decedent's Name (First, Middle,Last)				2. Date of Death		3. Time of Death
ledical Exami	ner	ZACHARY LEE BOSCHERT		1000		Month October 11		0240 hrs
)		4a. Facility Name (if not institution, give street and number) University Hospital		Baltimore	or Location of D	eath	4c. County of D	eath
Funeral		5 Social Security Number 6. Sex 7. Age (In yrs	s. last birthda				(MM/DD/YYYY) 9	. Birthplace (State or Foreign
Director			16	Yrs. Months D	Days Hours	Min. 6-20-	1990	Maryland Maryland
any		Usual Residence of Decedent  10a. State 10b. County 10c. C	ity, Town or	Location				10d. Inside City Limits
Maryland 28a-f show d at once.	'n	Maryland Anne Arundel Se	everna	Park				1 X Yes 2 No
Manyli 28a-f d at o	Director	10e. Street and Number		10f. Zip Code	е	10	g. Citizen of What	Country?
ith the Maryland 23a or 28a-f sho notified at once.		509 Leelyn Drive		211			U.S.A.	
Baltimore, MD 21215-0036  permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiewie Innorrant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status  1 X Never Married  2 Married  12. Was Decedent Ever in Armed Forces?  1 Yes 2 X No.		<ol><li>Was Decedent of If Yes, specify Cul</li></ol>		( Specify Yes or No- uerto Rican, etc.)	14. Race - A White, et	merican Indian, Black, lc.
after d il", or	by Fu	1 Yes 2 X No		1 Yes 2 X	No specify:		Specify:	White
nours a	q pe	15. Decedent's Education (Specify only highest grade completed)		cedent's Usual Occuring most of working			16b. Kind of Busine	ess/Industry
136 hin 72 l e. than "ı sdical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	1	ıdent			Educati	on
21215-0036 uld be filed within 7 Mental Hygiene, marked other than c event, the Medica	Co	17. Father's Name (First, Middle, Last)	1.		18.Mother's N	lame (First, Middle, M	aiden Surname)	
121 f be fill ental P arked vent,	Be	Richard J. Boschert				Rebecca Mo		And the state of t
D 2 should and M. is mainte	ျ	19a. Informant's Name/Relationship (Type, Print )				r or Rural Route Numb		
and 2 sho lealth and tem 27 is		Joan S. Montgomery - Grandmoth  20a Method of Disposition 20	er 39 b. Place of D	Oisposition (Name of	cemetery,	t, Hyattsv	ville, MD 20c Location - Cit	
Nore		1 X Burial 2 Cremation 3 Removal from State	·	or other place)	.11-	10/10/2006		
Baltimore, permit Pages I ar Department of Hee important: If ite	1	4 Donation 5 Other Specify: S1 21. Signature Funeral Service Licepsee		of the Mi	ess of Facility	10/19/2006 Gasch's Fu	Laurel,	Maryland
Dep Depring		Como lanta MOC373	5			Ave., Hyat		
Physician		2 a. Part I. Enter the disease, or complications that caused the defaallure. List only one cause on each line.	ath. Do not e	enter the mode of dyi	ng, such as card	iac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)		ntoxication				Death
1		or condition resulting in death)  Due to (or as a consequence b	e or):					
	iner	if any, leading to immediate Due to (or as a consequence cause. Enter Underlying Cause	e of):					
ed ssit	Examiner	(Disease or injury that initiated events resulting in death) Last	e of):					
executed ian and ial - transit		UNPENDED AMENDED						
760, cate be ev physiciar he burial	Medical	IF FEMALE: 23c. If yes, outcome of pr	egnancy				23d Date of del	ivery
Sox 687 leath certific e attending   for use as th	rsician/	23b. Was decedent pregnant in the past 12 months?	2 death		3 Ectopic pr	regnancy	Month	Day Year
Box 68 e death certif the attending ed for use as	ysic	1 Yes 2 No 9 Unknown 9 Unknown	death 5	Other (Specify)				
P.O. Is that the gned by t	by Phys	Part II. Other significant conditions contributing to death but no	ot resulting in	n the underlying caus	se given in Part I			e to the cause of death?
S, P.(	edk			<del></del>				Probably 4 Unknown
ords aw requinas been	Completed					24a Was a autops perforr	y prior	to completion of cause of
tal Rec sian: The l certificate l	Con					1 Yes 2		Yes 2 No
ital ician: s certil	Be	25. Was case referred to medical examiner?  1		26.PI	Other			
of Vital Records, ing Physician: The law requir After this certificate has been s uneral director, page 2 should t	 1	27. Manner of Death 28a. Date of Injury			Injury at Work?	28d. Describe h	Residence 6 🗸 C	
ion (tending eath tor: Aft the fun	Certification:	1 Natural 5 Pending Pro Mrth: Day, Year) 2 Accident Investigation Oct 6, 2006	FOUN 0849 h	1 11	Yes 2 V No	Deceased in	gvested metha	done
Division tal or Attendi rs after death al Director: △	tifica	3 Suicide 6 ✓ Could not be 28e. Place of Injury - A	t home, farm		ce building, etc.	or Town, St	ate)	r Rural Route Number, City
Ospital bours ineral y filled		4 Homicide determined (Specify) Single F				509 Leelyn D	rive, Severna	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Directors After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only one)  Certifying Physician: To the best of my knowledge of examination and manner stated						
- 5 ½ ½ S	Me	29b. Signature and title of certifier		29c. Lic	ense number		29d. Date signed	(Month, Day, Year)
	x-	XXXXXIV		О.	C.M.E.		October 14, 2	006
(3)	, No.	30. Name of address of person who completed cause of death (II Susan Hogan MD. Assistant Medical Examin	,	Penn Street, B	altimore, MD	21201		
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Sign						
Regis	trar	OCT 2 3 2006 Reserve D	1. 00	uli				

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State of Maryland / Department of Health and Mental Hygien 2 0 0 6

35748

						Certificate of	f Death		Reg. No.		
	Physici	an	1. Decedent's Name (First, Middle, La	st) Z	REU			2. Date of D Month	eath Day	Year	3. Time of Death
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ì	Examir		4a. Fecility Name (If not institution, given HCR Manor Care				Largo	, or Location of Dea	Princ	e Geo	
	Funeral Director		225-34-9661	ex 7. Ag  √2 M 2□F	e (In yrs. lest bir 75	thday) If Under 1 Yea Months Day		Min. (Month, E	oay, Year) 21,1931	9. Birthp Cour Virg	
	Maryland f show	tor	Usual Residence of Decedent  10a. State  10b. County  Maryland Prince G	oorgo!s	10c. City, Town					1	0d. Inside City Limits
	with the	Funeral Director	10e. Street end Number 6719 Stanton Road	eorge s	nyacts	10f. Zip Code	20784		10g. Citizen of V United S		
	er death	unera	11. Marital Status 12 Never Married 2 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2√2		13. Was Decedent of If Yes, specify Cu	f Hispanic Origin Joan, Mexican, F	n? (Specify Yes or N Puerto Rican, etc.)	Blac	k, White,	
0020	hours aft ural; or		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X N				Bla	
21215-0020	be filed within 72 hours after death with the Maryland nat Hyglene. d other then "netural", or items 23a or 28e-f show event, the Medical Examiner must be notified at	Completed by	15. Decedent's E. (Specify only highest grant Elementary/Secondary (0-12)	College (1-4or	5+)	Decedent's Usual Occ (Give kind of work don life. DO NOT use reti	upation ie during most o red)	f working	16b. Kind of Bu		
	be filed nta! Hygi of other event,	Be	Unknown 17. Father's Name (First, Middle, Last,		⊤ва	rtender	18. Mother's	Name (First, Middl	Univers e, Maiden Surnam	-	CIUB
Maryland	s 1 and 2 should be f f Health and Mental h tem 27 Is marked of other traumatic eve	욘	Unknown  19a. Informant's Name/Relationship (	** *		. Mailing Address (Stre	et end Number	or Rural Route Num		State, Zip	Code)
	ges 1 and of Health if Item 27 or other tr		Beathena E. Tate/ 20a. Method of Disposition 1段Burial 2□Cremation 3□		20b. Place of cemeter	Disposition (Name of,	emetery	Date	20c. Location -	leab.	
Baltimore,	permit. Pages 1 Department of H Important: If Ite any Injury or ot	9	4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Licer	y)	Union		Iress of Facility	Robert G.	Virginia Mason Fu	inera	1 Home Inc
ш	205 2		plan dag	hyp		1661 Good				200	20
7	Physician /Medical Examiner		23a. Part1. Enter the disease, or comshock, or heart failure. List only  Immediate Cause (Final disease or condition resulting in death)			not enter the mode of d					Approximate Intervel Between Onset and Death
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68760,	certificete be executed rding physician end use es the burial-transit	/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. As	Due to (or as a c		Meun	RIPPE	`		
P.O. Box	Physicien: The law requires thet the death certh rits certificate has been signed by the attending raid director, page 2 should be deteched for use e	Physiciar	Part II. Other significant conditions of	ontributing to death b			given in Part I.		d tobecco use con		o the cause of deeth? bably 4 ED€nknown
Division of Vital Records,	tw requires s been sign 2 should be	Completed by						24a. Wa	s an autopsy formed?	av co	ere eutopsy findings ailable prior to mpletion of cause deeth?
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/ita	ysicien: The last certificete hadirector, page	Be	25. Was case referred to medical examiner?					Death (Check only	one)		
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sion (	ending Phy eath. or: After thi the funeral o	Certification:	27. Menner of Death  1				☐Yes 2. DMG	5			J. Clauda Aliembas
Divi	Ital or Al Irs after ral Direc lled in by		4 ☐ Homicide determined	building, et	c. (Specify)	rm, street, factory, offic		City or To	(Street and Numb own, State)		
	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical	(Check only 2 Medical Examone)		f examination an	dor investigation, in my			e, date and place,	and due to	the cause(s)
	Tο Tο COΠ	<	29b. Signature and title of certifier	2	Mo	7	62 8	10	29d. Date signe	106	
			30. Name and address of person who	completed cause of c	death (Item 23a)	(Type, Rrint)	60001	were No	>, LAWH	Alry	Mo
	Sta Hegisti		31. Date filed (Month, Day, Year) OCT 2 3 200	32. Registr	rar's Signature	ford					

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiens 35749 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Wilbur E. Brown October 18, 2006 23:55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) 16, 1928 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1X M 2□ F 213-24-3121 78 Yrs **Director** Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Yes 2 No Director Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 3124 Gracefield Road #317 20904 USA items 23a deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. filed within 72 hours after 1 Never Married 20 Married 1X Yes 2 □ No ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White "naturai" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Painter/Paper Hanger Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: if fem 27 is marked oth any lijury or other traumatic event 2008. Be Clifton M. Brown Mae Sicken 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wife) Maria Brown 3124 Gracefield Road #317, Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ₽₩Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Ft. Lincoln Cemetery 10/21/2006 Brentwood, MD 21. Signature i Funeral Service Lice 22. Name and Address of Facility Rendon/Hale Funeral Home hom 9013 Annapolis Road, Lanham, MD 20706 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death inmediate Cause (Final disease or condition resulting in death) Physician 24 hours Secsis /Medical Due to (or as a consequence of): Examiner Intraabdominal infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 24 hours Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Urinary tract infection 24-48 hours and Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical Possible acute appendicitis 24-48 hours IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) be detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 Yes 2**/200**0 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Yes 2 No 1X Inpatient To the Hospital or Attending Phys within 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral dir 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b Signature and title of tertifier 29c. License number 29d. Date signed (Month, Day, Year) D0043375 October 19, 2006 10 30. Name and addre of person who completed cause of death (Item 23a) (Type, Print) Karen Merritt, M.D. 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

			1 - For State Registrar	State	of Ma			artme		ealth a	and M	fental H		0 0	06	35750
	Physicia	an	Decedent's Name (First, Middle		DD OI	n.						2. Date of D		ay	Year	3. Time of Death
	/Medic		BEVERLY		BROW	IN .						OCTOB	ER	23 2	006	1:10 A M
	Examin	er	4a. Facility Name (If not institution 4281 58th AVENU		number)				, Town, or DENSI		of Death		4		y of Death	GEORGE'S
*	Contract		5. Social Security Number	6. Sex	7. Age	(In vrs.	last birthday)		er 1 Year	If Under	24 Hrs.	8. Date of B	irth	1 1/1		pplace (State or Foreign
	<ul><li>Funeral</li><li>Director</li></ul>		579-72-0651	1□M 2ĀF	51	, ,	Yrs.	Months	Days	Hours	Min.	AUG 25	3ay 1 <sup>Y</sup> 99	55	WAST	TNGTON, DC
	p .		Usual Residence of Decedent 10a. State 10b. County			100 Cib	y, Town or Lo									1011-110-111
	laryla ahov	ō		E GEORGE	1.0		BLADEN:		C							10d. Inside City Limits 1 X Yes 2 □ No
	28a-i	rect	MD PRINC	E GEORGE	5		DLADEN	_	ip Code				10g. C	itizen of	What Co	
	d within 72 hours after deeth with the Maryland jiene. r than "natural", or items 23a or 28a-f ahow ite Medical Examinational be notified at	Funeral Director	4281 58th AVENU	JE # 4					784					U.S.		,
	deet	ner	11. Marital Status	12. Was De	ecedent E Forces?	Ever in U.	.S. 13. \	Was Dec	edent of Hi	spanic Ori	gin? (Sp	ecity Yes or N Rican, etc.)		14. Ra		ncan Indian,
9	or Ite		1 Never Married 2 Marr	ied 1 ☐ Yes	s 212 N Give	lo	ì		2 ₩ No	Specify:	i, Fuello	riican, etc.)		Speci		
215-0036	hours tural'	Completed by	3 ⊠ Widowed 4 □ Divorced	Year or	Dates:				77				1.05		. 11	ACK
Ċ	within 72 ene. then na	plet	15. Decedent (Specify only highes	st grade completed		,	16a. Deced (Give life. L	kind of w	ork done d use retired	during mos ()	t of work	ing	160.	Kirid of E	Business/I	ndustry
7 7	d with	mo;	Elementary/Secondary (0-12)	College	(1-4or 5	+)	SUPE	RVIS	OR				PR	IVAT	E	
2	be filed ital Hygid of other avent, II	Be	17. Father's Name (First, Middle,	Last)						18. Mothe	r's Nam	e (First, Middi	e, Maide	n Suma	тө)	
yland		မှ	DILLARD WILLI							YVO		HENDE				
Ma	O1 00		19a. Informant's Name/Relations DARLENE TRULL/					_				al Route Num V ATTCT				ip Code) D 20784
	item 27		20a. Method of Disposition	DIDIEK		20b. P	lace of Dispo	sition (N	ame of	1		Date	_			Town, State
<u>ē</u>	Pages nent of int: if it		1 ☐ Burial 2 ☼ Cremation 4 ☐ Donation 5 ☐ Other (S)		m State	6	emetery, cren VERDAL	natory or	other place	1	0-23	3-2006				iaryland
Baitimore,	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service		11	/			and Addres							RAL HOME
ñ	De Tie		K.D. M	-had	11		7	474	LANDO	VER R		LANDOV				20785
	Physician		23a. Part1. Enter the disease or shock, or heart failure. List Immediate Cause (Final	only one cause or	n each lin	Θ.	h. Do not ent						arrest,			Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	- u.			uence of):	TECI	ENCI	SIND	KOPIE	1				
	Examiner		Sequentially list conditions.	b												
٦	ed isi	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due t	to (or as a	a conseq	uence of):									
	xecut and	xan	that initiated events resulting in death) Last	c	to (or as a	a conseq	uence of):									
/eg,	ate be executed hysicien and the burial-transit	cai		L <sub>d</sub>												
9	death certificate be executed e attending physicien and nd for use as the burial-transit															
ž	death certific attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	outcome o			Ectopic	pregnancy						ate of deli	
j.	at the dea by the at tached fo	/sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pre 9□Uni	gnant at known	time of d		Other (						M	onth	Day Year
J.	res thet the		Part II. Other significant condition	ns contributing to	death bu	ut not res	ulting in the u	nderlving	cause give	en in Part I		23e. Dio	Itobacco	use con	ntribute to	the cause of death?
g S	requires thet the	d by										10	] Yes	2 🗆 No	3 🗆 Pro	obably 4 🖺 Unknown
ecord		Completed										24a. Wa	s an	24b.	Were au	topsy findings available
r	o - o	Шo										per	opsy formed?		death?	topsy findings available completion of cause of
Vita	ician: Th certificete rector, pag	Bec	25. Was case referred to medical examiner?							26. Place	of Deat	1 ☐ Yes h (Check only		10	1 103	2010
5	Physician: this certific ral director.	To	1 A Yes 2 No				ER/Outpatien	t 3 🗆 🛭		4 🗀 140	irsing Ho	ome 5⊠Re	sidence	6 <b>□</b> Ot	her (Spec	cify)
	ling After une	lon:	27. Manner of Death 1 ⊠Natural 5 ☐ Pendin		te of Injur o <i>nth, Day</i>	y Year)	28b. Time of Injury		28c. Injury Work		-	28d. Describe	how in	ury occu	rred	
Division	tten deat tor: the	icat	2 Accident investig	not be	ce of Iniu	inc. At he	ome, farm, str	M cot foots		Yes 2 🗌	No	28f Location	/Stroot	and Num	bar or Du	ral Route Number,
2	i Ditte	Certification:	4 Homicide determ	ined bui	ilding, etc	. (Specif	y)	eet, facto	лу, опсе			City or T	own, Sta	ite)	Der or Mu	rai Houle Number,
	To the Hospitai within 24 hours a To the Funerel I completely filled		29a. Centrier 1 Certifyin	g Physician: To t	the best o	of my kno	wledge, death	occurre	d at the tim	ne, date an	d place,	and due to th	e cause	(s) and m	anner as	stated.
	the Hi in 24 the Fu ipletel	Medicai	one) 2 Medical	and ma	basis of anner sta	examina	tion and/or in	vestigatio	on, in my op	oinion, dea	ith occur	red at the time	date a	nd place	, and due	to the cause(s)
	To the within 2 To the complet	2	29b. Signature and title of certifie	1///	7	,		2	9c. License							n, Day, Year)
1	10		Ma.	July	/	L	W		D003	1329			1(	1/ 43/	/2006	
2	(4)		30. Name and address of person RONALD C. WHEI	with completed ca ELER,MD 1					IE LAI	RGO,	MD 2	0774				
	Sta	ite	31. Date filed (Month, Day, Year)	1 00	D inter	1 0:										
	Registr		OCT 24 2	JUB /se	du	D.	Joe-	2								

			For State Registrar	State	e of Marylar	nd / Depa <i>Cei</i>	artment of F	lealth and I Death		iene 006	35751
	Physici	an	Decedent's Name (First, Middle     ANGEL A		VI OD				2. Date of Deat Month	Day Year	3. Time of Death
	/Medic	al	ANGELA  4a. Facility Name (If not institution		YLOR		4b. City. Town. o	r Location of Death	OCTOBER	15 2006 4c. County of Dea	4:41 A M
	Examin	er	SOUTHERN MARYI				CLINTON				GEORGE'S
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 📆	F	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) C	rthplace (State or Foreign ountry)
	Director		578-56-2358 Usual Residence of Decedent		66	115.			AUGUST	12 1940 WA	ASHINGTON, DC
	nyland how		10a. State 10b. County			ity, Town or Lo					10d. Inside City Limits
	Ba-f	Director		GEORGE	'S (	CAPITOL	HEIGHTS				1 ∑Yes 2 No
	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hyglene. Important: If Item 27 is marked other than "naturel", or Items 23a or 28a-f ehow entry injury or other treumatic event, the Misclical Examinar must be notified at anote.	i Dir	10e. Street and Number 1218 ADELINE W	AY			10f. Zip Code 20743		10	Og. Citizen of What C	ountry?
	ms 2	Funeral	11. Marital Status		Decedent Ever in U		Was Decedent of H f Yes, specify Cuba	lispanic Origin? (S	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi	
36	rs after	by Fu	1 Never Married 2 Marr 3 Widowed 4 Divorced	ied 1 PAY	d Forces? 'es 2 □ No ARI s, Give or Dates:2 / 80·	MI I	1 ☐ Yes 2 ☑ No	Specify:		Specify: B	
8	2 hour		15. Deceden	t's Education		16a. Deced	ient's Usuat Occup		4	16b. Kind of Business	
215	ithin 7.	Completed	(Specify only higher Elementary/Secondary (0-12)		ge (1-4or 5+)	life. I	kind of work done DO NOT use retired ERK	during most of wor d)		PRIVATE	
2	Hygier ther th		12th 17. Father's Name (First, Middle,	Last)		CL	EKK	18. Mother's Nan	ne (First, Middle, M		
Maryland 21215-0036	ld be f ental h ked ol	o Be	PAIGE THOMAS I						AGNES WAR		
ary	and M		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (Street	and Number or Ru	ral Route Number,	City or Town, State,	Zip Code)
<b>Σ</b>	l and deelth		JAMES BAYLOR/BE	ROTHER	20h		BARLOWE sition (Name of	RD LANDOY	VER, MARY	I.AND 2078 20c. Location - City of	
Baltimore,	eges int of h t: if he		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		rom State	cemetery, cren	natory or other plac	1		ŕ	
alt:	mit. P partme portan / Injur		21. Signature		l PI.					HELTENHAM INS FUNERA	
<u>~</u>	9 0 E 9			8						R, MARYLANI	
			23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause	on each line.			ng, such as cardiac	or respiratory arre	est,	Approximate Intervat Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. U	e to (or as a conse	1 BUS	EEP.				
	Examiner				ASTRITI						
	ν ±	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		e to (or as a conse	,					
	and and II-trans	Examiner	that initiated events resulting in death) Last	c. Due	e to (or as a conse	quence of):	10 mg	PISCASE			10 4840
8760,	icate be executed physicien and s the burial-transit	dical E		d. L	e to (or as a conse	4 41	pilly	3LPJ-C1Q	ing No.		20 4ELL5
9	ntificat ng phy a as th	0 1	IF FEMALE:	1							
Box	The law requires that the death certific ate has been signed by the ettending p page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 1 L	, outcome of pregr ive birth 2 ☐ Fet regnant at time of	al death 3	Ectopic pregnancy	,		23d. Date of de Month	elivery Day Year
Р. О.	that the de led by the e detached i	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Inknown	death 3	Other (specify) _				
o. O.	es that igned b	by P	Part II. Other significant condition	4			nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute t	to the cause of death?
ord	w require been si should l	ted	PUCH	siry	2400	L1374			1 ☐ Ye	s 2 □No 3 □ P	robably 4 ∰Unknown
Division of Vital Records,	has b	Completed			<del></del>	·			24a. Was ar autops	y prior to	utopsy findings available completion of cause of
tal	an: The	Be Co	25. Was case referred to medica		11			26 Place of Dea	1 Yes 2	UNo 1₩ Ye	s 2□No
<b>\S</b>	nysick nis cer	To B	examiner? 1 ☐ Yes 2 ☑ No	11	1 Inpatient 2	] ER/Outpatien	t 3 DOA Oth	0.5		nce 6 □Other (Spe	ecify)
o no	ling PI		27. Manner of Death 1 ☑ Natural 5 ☐ Pendin	9	ate of Injury Month, Day Year)	28b. Time of Injury	Wor		28d. Describe ho	w injury occurred	
isic	death ctor: / y the f	ficat	2 Accident investig	not be	Place of Injury - At I	nome, farm, str		Yes 2 □No	28f. Location (St	eet and Number or R	lural Route Number.
5	al or A s after at Direct	Certification:	4 Homicide	lined t	ouilding, etc. (Spec	ify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town	, State)	
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funsral Director: After this certificate his completely filled in by the funeral director, page	Medical (	29a. Certifier 1 Certifyir (Check only one) 1 Medical	Examiner: On t	o the best of my kn he basis of examin manner stated.	owledge, death ation and/or in	n occurred at the tir vestigation, in my o	me, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and manner a ite and place, and du	s stated. e to the cause(s)
	To the To the complet	Me	29b. Signature and title of certifie	r			29c. Licens	e number	25	d. Date signed (Mon	
^			MARC	yer	M	>	10	06412	7	10/19/20	06
L	(3)		30. Name and address of person ADAM PEARLMA	· ·	cause of death (Ite 7801 BRAN		•	202 CLI	NTON, MARY	TAND 207	35
	Sta Registi		31. Date filed (Month, Day, Year)  OCT 2 4	2006	32 Registrar's Sign	o. Sp	W.				

			1 = For State Registrar	State of Maryland		ent of Health and ate of Death	d Mental Hy	giene (	006	35752
	Dhysisi		1. Decedent's Name (First, Middle, Last)				2. Date of De	eath Day	Year	3. Time of Death
	Physici: /Medic		Earl Lamont B	aker			60000	B22		08.15A M
	Examin	er	4a. Facility Name (If not institution, give s		FF	City, Town, or Location of D	~		unty of Deat	
			BALTIMERE TO ASHIM		- 1	Chen St.				PUNIDEL
M	Funeral		5. Social Security Number 6. Sex	M 2DF	Yrs. Mon		Ain. (Month, Da	y, Year)		hplace (State or Foreign untry)
	Director		578-92-6473 X	42			March	21,19	964 V	Wash DC
	yland Now		10a. State 10b. County	10c. City	, Town or Location					10d. Inside City Limits
	Mar Ified	ţ	MD Anne Aru	ndol Glo	n Burni	۵				1 ☐ XYes 2 ☐ No
	th the	Director	10e. Street and Number	HOEL TOLE		. Zip Code		10g. Citizen	of What Co	untry?
	th wi		418 Secluded Pos	st_Circle	2	1061		USA		
	em.	Funerai		2. Was Decedent Ever in U.S Armed Forces?		ecedent of Hispanic Origin specify Cuban, Mexican, P	(Specify Yes or No uerto Rican, etc.)		Race - Ame Black, White	
9	or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give		s 2 No Specify:	•		ecityB1a	
5-0036	should be filed within 72 hours after death with the Maryland of Menal Hygiene. Thygiene 28a or 28a-f ehow marked other then "natural", or tieme 28a or 28a-f ehow marked other then "natural" or tieme 28a or 28a-f ehow matic event, the Madical Examiner must be notified a		3 Widowed 4 Divorced	Year or Dates:	1Co Decederate	1				
<u>.</u>	within 72 ene. then "nation	Completed	15. Decedent's Educ (Specify only highest grade	completed)	16a. Decedent's (Give kind o life. DO NO	f work done during most of T use retired)	working	160. Kind	of Business/	industry
7	with ene then	m o	Elementary/Secondary (0-12)	College (1-4or 5+)		,		Priva	2 + 2	
0	Hygie bther out,	a)	17. Father's Name (First, Middle, Last)	1	retail	manager   18. Mother's	Name (First, Middle			
<u>a</u>	ould be Mental arked o	To B	Hovt Baker			Betty	Jean Gi	bbs		
Maryland	2 should and Men le marke aumatic	-	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailing Add	ress (Street and Number of			wn, State, Z	<sup>(ip Code)</sup> 20743
_	カイトン		Betty Jean Saund	ders-Mother	1114 Ca	stle Haven	Ct. Car	ital	Reig	
altimore,	permit. Pages 1 and Depertment of Healt Important: If Item 2 eny injury or other once.	1	20a. Method of Disposition	20b. Pl.	ace of Disposition	(Name of	Date	20c. Locat	ion - City or	Town, State
Ĕ	Pages nent of int: If It iry or o		1   Burial 2 □ Cremation 3 □ Re  □ Donation 5 □ Other (Specify)	Ced	ar Hill	Cemetery	10/26/06	Sui	tland	, MD
a	permit. Depertrimports eny inju		21. Signature of Funeral Service License	98	22. Nam	e and Address of Facility	Cedar Hi	11 F	unera	1 Home
<u></u>	89229		Mary Hedgman	Mo 1374	4111	Penn Ave.				
П			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death e cause on each line.	. Do not enter the	mode of dying, such as car	diac or respiratory a	rrest,		Approximate Interval Between
41	Physician		Immediate Cause (Final disease or condition	AIDS.						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	,					
	3	_	Sequentially list conditions, b	Due to for as a consequ	EFE	WAL DISE	ASE			
	ted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		2 D-1	2020				
,	sate be executed thy sicien and the burial-transit	Examiner	that initiated events c resulting in death) Last	Due to (or as a consequ		Si-Den				
8760	cate be ex physicien the buria	dical	<b>U</b> ∂							
9		Medi	IS SSIAN S		_					
Вох	eath certific ettending p	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Bc. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal		ic pregnancy		23d	. Date of deli	
	The faw requires that the death certificate thes been signed by the ettending page 2 should be detached for use as	Physician/Me	1 Yes 2 No	4 Pregnant at time of de 9 Unknown	ath 5 ☐ Othe	(specify)			Month	Day Year
P.O.	that the de ed by the e detached t	Ph)	Part II. Dther significant conditions con	tributing to death but not resu	Iting in the underlyi	no cause given in Part I	23a Did	obacco use	contribute to	the cause of death?
Vital Records,	uires the signed I d be det	d by		•	,	,		Yes 2 □ N		
Sor	w requir been s should	Completed					24a. Was	an 2	4h Were au	toney findings available
Ř	he lav e hes ige 2	ш					- auto	ormed?/	death?	topsy findings available completion of cause of
a	ysician: The is certificete hi director, page	CO	25. Was case referred to medical			26 Place of	1 ☐ Yes  Death (Check only	2 No	1 ∐ Yes	2 No
>	ysicii Is cer direct	To B	examiner?	ospital: 1 patient 2 E	ER/Outpatient 3	Othor	g Home 5 ☐ Resi		Other (Snec	rufu)
0	Attending Physician: r death. ector: After this certifice by the funeral director, i		27. Manner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe			
joi	uttendin death. ctor: Af y the fur	atio	1 Aratural 5 Pending investigation	(Marin, Bay 7 day)	М	1 ☐ Yes 2 ☐ No				
Division of	t or Atte after de Directo	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm, street, fa	ctory, office	28f. Location ( City or To	Street and N wn, State)	u <i>mber or R</i> u	ral Route Number,
Ω	urs af									
	Hospite 24 hours Funeral stely filled	Medical	29a. Certifier 1 Certifying Physical Check only 2 Medical Examination	icion: To the bast of my know er: On the basis of examinati	vledga, išeath sedu ion and/or investiga	red at the time, date and platfon, in my opinion, death o	and due to the courred at the time,	date and pla	d manner as ice, and due	stated. to the cause(s)
	To the Hospitet or Attending Ph within Z4 hours after death. To the Funeral Director: After th completely filled in by the funeral	Mec	29b. Signature and Me, of certifier	and manner stated.		29c. License number		29d. Date si	gned (Month	n, Day, Year)
į	ઇ ને દ ન		13 Oslobe	2			-	Chris	252	120 Bearing
)	(2)		30. Name and advess of person who co	mo ted cause of death (Item	23a) (Type Print)	0 73.77			, , x time	- 7 2006
	9		QNAZATO 30		rive	9-45149 Gleu Born	re- ME	s De	100	
1	Sta	te	31. Date filed (Month, Day, Yeer)	32 Registrar's Signat	ure /					
	Registr	ar	OCT 24 2006	Deser D.	specie					

			For State Registrar	State of N	Marylan	-	artment o			nd Me			006	35753
	Physici		Decedent's Name (First, Middle ESSEX		BOWENS	 S						-	2006	3. Time of Death 4: 22P M
	/Medic Examin		4a. Facility Name (If not institution	n, give street and numbe	er)		4b. City, Tov	wn, or Lo	ocation of	Death	-	4c. 0	County of Death	1
			PRINCE GEORGES	HOSPITAL C	CENTER				ERLY	2. Date of Death	GEORGES			
	Funeral Director		5. Social Security Number 237 52 4132 Usual Residence of Decedent	6. Sex 7	Age (In yrs. I	3 Yrs.	If Under 1 Y Months D		Hours	Min.	Date of Birth (Month, Day )CT • 19	Year) , 19	Cor	place (State or Foreign intry) TH CAROLINA
	/land		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	a-fsh	ctor	MD PRINCE	GEORGES	CA	APITOL	HEIGH'	ГS						XXYes 2 □ No
	or 28	Olre	10e. Street and Number				10f. Zip Co	ode				l0g. Citiz	en of What Cou	untry?
	s 23a	rall	906 APPLEWOOD					0743						
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic avent, the Medical Exacting rough be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Marr  3万√Widowed 4 □ Divorced	If Vas Give	es? <b>∐N</b> o		Was Decedent If Yes, specify 1 □ Yes 20		Mexican, Specify:	in? (Specifi Puerto Ric	ty Yes or No- can, etc.)		Black, White	, etc.
21215-0036	2 hou	ted	15. Deceden	t's Education		16a. Dece	dent's Usual O	ocupation	on			16b. Kin	d of Business/I	ndustry
215	thin 7	Completed	(Specify only highes Elementary/Secondary (0-12)	St grade completed)  College (1-4c	or 5+)	life.	na oi work a DO NOT use r	one aur etired)	ring most	ot working				
21	ygien ygien her th		4TH	/			FARMI		0.14-4	A- N 11	Fig. 1. 3 41-4-4-	B.6-1-1		re
Maryland	l be fill ntal H ed otl	Be	17. Father's Name (First, Middle,					11						
3	hould d Mer marke matic	<sup>2</sup>	WILLIAM BOWENS  19a. Informant's Name/Relations			19h Mailie	ng Address (S	treet and						in Cade)
Z	id 2 s Ith an 27 is i			DAUGHTER			APPLEW(							
re,	s 1 ar f Hea itam other		20a. Method of Disposition			lace of Dispo	sition (Name on matory or other	of						
Ë	Page: ient o nt: If ry or		XX Burial 2 ☐ Cremation `4 ☐ Donation 5 ☐ Other (S		110		CEMTE		1	0/21/	2006	ELM	CITY.	NC
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Service	Licensee			2. Name and A	Address ALL	of Facility S FUI	, NERAL	HOME	OF M	ARYLAND	,INC.
	111		23a. Part 1 Enter the disease, or shock, or heart failure. List	complications that caus	sed the death	. Do not ent							D , ID .	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	, END ST		LZHEIM	ER'S							Onset and Death
	/Medical Examiner		resulting in death)	а	as a consequ									
	Lxammer	_	Sequentially list conditions,	b ASPIRA			NIA							
	ted	Examiner	cause. Enter Underlying Cause (Disease or injury	24310 (01	as a consequ	service or y								
,	arecu n and al-tra	xar	that initiated events resulting in death) Last	c Due to (or	as a consequ	uence of):								
8760,	cate be executed physician and the burial-transit	ical		d										
9	tificat ng phy as th		PHOTO CONTRACTOR OF THE PARTY O	_			-0-0							
Вох	death certific e attending pl id for use as t	Physician/Med	23b. Was decedent pregnant	23c. If yes, outcor 1 ☐ Live birth	me of preg <i>n</i> a n 2 ∐Fetal		Ectopic pregr	nancy				23		•
о. Е		sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown	t at time of den	eath 5	Other (specif	fy)					MOHEI	Day rear
P.(	res that the de signed by the a be detached f		Part II. Other significant condition	ons contributing to deat	h but not resu	ulting in the u	nderlying caus	se aiven	in Part I.		23e. Did to	bacco us	e contribute to	the cause of death?
ds,	law requires that the as been signed by th 2 should be detache	d by	,	3			,	<b>g</b>						
ecords,	w require been sig	Completed									24a Wasa	n l	24b. Were aut	onsy findings available
$\alpha$	The lay	dmo									autop: perfor	sy med?	prior to co death?	ompletion of cause of
Vital		Ø	25. Was case referred to medical	1				2	26. Place of	of Death ((			T L Tes	2 NO
Ž	Physician: this certificral director,	To B	examiner? 1 □ Yes 🏋XNo	Hospital:	atient 2	ER/Outpatier	nt 3 DOA	Other:	4 🗆 Nurs	sing Home	5 🗆 Resid	ence 6	☐Other (Spec	ify)
n of	ding Phy h. After thi funeral o		27. Manner of Death  XX☐ Natural 5 ☐ Pendin	28a. Date of li (Month, i	njury Day Year)	28b. Time o Injury	28c.	injury a Work?	t	286	d. Describe h	ow injury	occurred	
sio	Attanding r death. ector: After y the fune	catl	2 Accident investig	gation not be			М		s 2 🗆 N					
Division	or At after of Direct in by	Certification;	4 Homicide determ	uned 286. Place of	Injury - At ho , etc. <i>(Specif</i> y	me, farm, sti	eet, factory, of	ffice		281			Number or Rui	ral Route Number,
	To the Hospital or Attant within 24 hours after deatl To the Funaral Director: completely filled in by the		29a. Certifier XIX Certifyir (Check only 2 Nedical	ig Physician: To the be	est of my know	wledge, deat	n occurred at t	he time,	date and	place, and	d due to the c	ause(s) a	and manner as	stated.
	the Hin 24 tha Fa	ledical	one)	and manner	stated	non attiwor in	-			1 occurred				
	To the within To the comple	Σ	29b. Signature and title of certifie	1 / Min	1/1	1.16		icense n			2			
$\wedge$	6		sellay!	1/00	My	14/1	-	2195	4			осто	BER 18,	2006
1	(8)		30. Name and address of person EDWARD MOSLE				Print) WOOD LA	AURE	L WA	Y B	SOWIE.	MD 2	0721	
	Sta	ite	31. Date filed (Month, Day, Year)											
	Registr		OCT 242	006 Bade	istrar's Signar	Spen	B)							

		•	1 - For State Registrar	State of Marylan		artment of H			ene 006	35754
324	Physici	an	Decedent's Name (First, Middle, Last					2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	al	RODNEY M BROCKING  4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	OCTOBER	16, 2006 4c. County of Deat	3:25P M
4		-	SOUTHERN MARYLAND	HOSPITAL CEN	TER		LINTON		PRINCE	GEORGES
	Funeral Director		5. Social Security Number 6. Se	TUM 2□F	Vre	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)   Co	nplace (State or Foreign untry)
			Usual Residence of Decedent		/8			JUNE 29	, 1928 WA	SHINGTON, DC
	death with the Maryland me 23s or 28s-f ehow	'n	10a. State 10b. County		y, Town or Lo					10d. Inside City Limits  XXYes 2 □ No
	1288-f	Directo	MD PRINCE G	EORGES U.	PPER M	ARLBORO		10	g. Citizen of What Co	
	th with		9707 GOLDEN EAGLE	COURT		20772	2		UNITED STA	ATES
	er dea	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. \	Was Decedent of H f Yes, specify Cubi	dispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
036	72 hours after natural", or ite	þ	X1 X Never Married 2 Married 3 Widowed 4 Divorced	tytyes 2 □ No If Yes, Give Year or Dates:		Yes <b>XX</b> No	Specify:		Specify: B	LACK
215-0036	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	ucation le completed)	(Give	lent's Usual Occup	during most of work	ang 1	6b. Kind of Business/	Industry
	within ene. then	dmo	Elementary/Secondary (0-12) 12TH	College (1-4or 5+)		OO NOT use retired KERY OPEI			PRIVATE	
מ	a filed Il Hygi other	Be Co	17. Father's Name (First, Middle, Last)		DA	KEKI OFEI	,	e (First, Middle, M		
ylar	should by and Menta warked	ToE	NATHAN BROCKINGTO				L	LINE ALFO		
Maryland 2	2 8 2 5	1 3	19a. Informant's Name/Relationship (T) ERIC BARKSDALE /						City or Town, State, 2 RLBORO, MD	
	of Health	1	20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of natory or other plan			Oc. Location - City or	
Baltimore,			XIX Burial 2 Cremation 3 4 Donation 5 Other (Specify)	Hemovai from State			CEM. 10/	23/2006	LAUREL, 1	MD
Ball	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service Licens	sfll		4308 SUIT	LAND ROA	D SUITLA	F MARYLAND AND, MD 20	, INC. 746
ı			23a. Part1 Enter the disease, or comp shock or heart failure. List only o Immediate Cause (Final	lications that caused the death ine cause on each line.	h. Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a consequ	uence of):	ulu p	Prosta	h Ca	nees !	Inthon
ı	Examiner		Sequentially list conditions.	b						
	ted nslt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	uence of):					
oʻ	be executed siclen and burial-transit	Exai	that initiated events resulting in death) Last	Due to (or as a consequence)	uence of):					
8760	cate be physicle the bu	dical		d						
Box 6	eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna	incy				23d. Date of deli	iverv
о. В	The law requires that the death certificate be executed to hes been signed by the attending physicien and age 2 should be deteched for use as the burial-transit	Physician/Me	in the past 12 months?  1 Yes 2 No 9 Unknown	1 □Live birth 2 □Fetal 4 □ Pregnant at time of di 9 □ Unknown		Ectopic pregnance Other (specify)	y		Month	Day Year
S, G	res that igned to be dete	by PI	Part II. Other significant conditions co	intributing to death but not res	ulting in the u	nderlying cause giv	ren in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ord	w requir been si should	eted	flind far	luc				1 🗆 Ye	s 2 No 3 Pr	obably 4 Genknown
Rec	The law	Completed	a Meni-					24a. Was an autopsy perform	prior to d	topsy findings available completion of cause of
Vital Records,		0	25. Was case re red to dical	SION			26. Place of Deal		□N6 1 □ Yes	2□ No
	Attending Physicien: r death. sctor: After this certific by the funeral director,	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	ER/Outpatien	3 DOA	ner: 4 Nursing Ho		nce 6 Other (Spec	cify)
U <sub>O</sub>	ding P h. After I funera	tlon:	27. Mann of Death  1 atural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	ryat rk? Yes 2 □No	28d. Describe hor	w injury occurred	
Division of	r Attenter deatlinector:	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	286. Place of Injury - At no			163 2 100		eet and Number or Ru	ral Route Number,
	ital or A		4   Hornicide	building, etc. (Specify	y) 			City or Town	State)	
	To the Hospital or within 24 hours after To the Funeral Director completely filled in	edical	29a. Certifier 1 Certifying Phy 2 Medical xam	vsician: To the best of my kno iner: On the basis of examina a manner stated.	wledge, death tion and/or in	occurred at the tweetigation, in my o	me, date and place, opinion, death occur	and due to the ca red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Σ	29b. Sig ture and title of tifler	, )		29c. Licens			d. Date signed (Monti	
	2		30. Name and address of person who a	ompleted cause of death (Item	23a) /Tune	Print)	154	00	1013cm	1206
1	4		ARASTOO YAZINANA	1-1 000-11	- est (Type,	- Ale 3	-4/8,1	ues S PR	foses,1	20902
	Sta Registi		31. Date filed (Month, pay, Year)  OCT 2 4 2006	32. Registrar's Signa	doer doer	d)			J	
	3			1 / Language /	/-/-					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** October 17, 10:30 P.M 2006 Ethel Lee Wade King Bethea /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges HCR Manor Care of Largo Largo If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 3, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 □ M 2 X F 72 North Carolina 176-28-6560 1934 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 □ No Maryland Prince Georges Landover Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 20785 United States 410 Stevenson Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married and Mental Hygiene. Is marked other than "natural", or i Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No **Black** Specify þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th grade Housekeeper Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic evonce. Kattie Mittie McGuire Sherman Wade 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Clara Marie Adams (Daughter)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZEE

31. Date filed (Month, Day, Year)

OCT 2

0 2006

ABIODUN

1 X Burial 2 ☐ Cremation 3 ☐ Removal from State

4 □ Donation 5 □ Other (Specify) 21. Shinatur of Funeral Service Acensee

20a. Method of Disposition

**Physician** /Medical Examiner

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

signed by

page 2

	21. Strinature of Funeral Service Acen	D. Martin	R. N 600	and Address of Facility Horton Comp Kennedy Stree	any Mortic t, N.W.;Wa	ians, In shington	c. ,D.C. 20011		
	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.				Ł	Approximate Interval Between Onset and Death		
al Examilie	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence o	uence of):	e VARCULAN	vent.	5E			
2		. d							
ysicial l/life	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ Mo 9 □ Unknown	23c. If yes, outcome pf pregnative birth 2 ☐ Feta 4 ☐ Pregnant at time of continuous forms.	al death 3 □Ectopic		<u> </u>	23d. Date of de Month	elivery Day Year		
L n n	Part II. Other significant conditions o	ontributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did tobacc		o the cause of death?		
analdino		24a. Was an autopsy performed?							
ú	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)				
2	1 ☐ Yes 2 ☐ ¥6	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ [	OOA Other: 4 Nursing I	Home 5 ☐ Residence	e 6 □Other (Spe	ecify)		
arion:	27. Manner of Death 1 ☑ Maîural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred			
erillic.	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, factory)	ory, office	28f. Location (Stree City or Town, S	t and Number or Fi tate)	lural Route Number,		
edical		nysician: To the best of my kno niner: On the basis of examina and manner stated.							
MIC	29b. Signature and title of certifier		M/>	9c. License number	29d.	Date signed (Mon	th, Day, Year)		

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

410 Stevenson Lane; Landover, Maryland 20785

Date

Oct.21,2006

20c. Location - City or Town, State

ROPP, LAMHAM, MO,

Brentwood, Maryland

DHMH 17 Rev 1/2001

Registrar

24 hours a

GOODLUCK

			For State Registrar	State of Ma	aryland / Dep	partment o	of Health a	nd Mental F	lygiene	2006	3575	6
			Hegistrar     Decedent's Name (First, Middle, Las	t)		runcate	UI Death	2. Date of			3. Time of Death	<u> </u>
	Physici /Medio		Marianne Bidd:	le				Octol	oer 2	2,2006	4:42p	М
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, To	wn, or Location of	f Death	4c.	County of Dear	h	
			302 Park Circ		the contract that t		kton	M Hrs. a. a.		Cecil		
	Funeral Director		5. Social Security Number 6. Security Number 219-44-6492  Usual Residence of Decedent	7. Age □M 2 <b>]</b> (X) F	61 Yrs.		Year If Under 2 Days Hours	Min. Septei	Day, Year) <b>nber</b>	23, 192	hplace (State or Fore	ign ——
	yland now		10a. State 10b. County		10c. City, Town or	Location	· · · · · · · · · · · · · · · · · · ·				10d. Inside City Lim	its
	a-f-er	cto	MD Cecil		E1kt	on					1X∑Yes 2⊡	VO
	ith th	Funeral Director	10e. Street and Number			10f. Zip Co			_	izen of What Co	untry?	
	ath w	ral	302 Park Circ			219		. <u> </u>		S.A.		
	ter de	-un-	11. Marital Status  1 Never Married 2X Married	12. Was Decedent 8 Armed Forces? 1 Yes 2 X	ever in U.S.	If Yes, specify	t of Hispanic Orig Cuban, Mexican,	gin? (Specify Yes or , Puerto Rican, etc.)	No-	14. Race - Ame Black, Whit		
980	al', or	[호	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀	No Specify:			Specify: W	nite	
21215-0036	within 72 hours after death with the Maryland ane. then "netural", or Iteme 23e or 28e-f ehow the Medical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	/Gii	edent's Usuaf C	done during most	of working	16b. K	ind of Business	Industry	
121	within 100.	Idm	Elementary/Secondary (0-12)	College (1-4or 5	+)	ice Ma	retired)	•		Med	ca1	
9	Hygi Hygi Sther		12 17. Father's Name (First, Middle, Last)	<b>L</b>	OII	ice no		r's Name (First, Mid	dle, Maiden			
lan	should be nd Mental marked c	То Ве	Harry E. Futt	V			Dor	othy Sh	epard	3		
Maryland			19a. Informant's Name/Relationship (7		19b. Ma	ling Address (S	treet and Number	r or Rural Route Nu	mber, City o	or Town, State, 2	Zip Code)	
	of Heelth of Heelth of Heelth of Itam 27 i		Patrick S. Bid	dle Sr./				rcle, E			21921	
Baltimore,	ges 1 It of H if Ital		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐	Removal from State		ematory or othe	r place)	October		ocation - City or	Town, State	
臣	permit. Pages Department of P Important: if Ite any Injury or of any Injury or of angles.		4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Fundal Service Licen		R.C.	irate (	Concept Viess of Facility	25,20	06	E1ktor	n, MD	
Ba	Department of the control of the con		110	300		Andrew	√ G. Ge	e Funer				
		Н	23a. Part1. Errer the disease, or comp	lications that caused	the death. Do not e	$259~\mathrm{E}_{ extsf{0}}$	Main of dying, such as d	St., E1:	kton , y arrest,	MD	21921 Approximate	
Ų	Pnysician		shock, of heart failure. List only of Immediate Cause (Final disease or condition	a Bred	-	cer					Interval Between Onset and Death	
	/Medical		resulting in death)	Due to (or as	a consequence of):							
ı	Examiner		Sequentially list conditions,	U. The state of th	CONTRACTOR OF STREET	Can	cer				Une	
	led Islt	Examiner	if any, leading to intribudate cause. Enter Underlying Cause (Disease or injury	Lua to (or as	a consequence of).							
<u>,</u>	te be executed ysicien end le burial-transit	xan	that initiated events resulting in death) Last	c. Due to (or as a	a consequence of):							_
8760,	cate be executed obly sicien end the burial-transit	call		d.								
9	ng ph as th		IF FEMALE:									-
Вох	death certifica e attending ph of for use as th	lan/	23b. Was decedent pregnant		2 Fetal death 3	□Ectopic pregr	nancy			23d. Date of del Month	ivery Day Year	
P.O.	the de	Physician/Med	in the past 12 menths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant at 9□ Unknown	time of death 5	Other (special	fy)		-	WOTT	Day 18a1	
	law requires thet the deas been signed by the a	y Ph	Part fl. Other significant conditions co	ontributing to death bu	ut not resulting in the	underlying caus	se given in Part I.	23e. D	id tobacco u	use coptribute to	the cause of death?	
Records,	w requires been sign should be	ed by						1	☐Yes 2	<b>3</b> No 3□ Pr	obably 4 Unknow	₩n
900	law re	Completed						24a. W		24b. Were au	topsy findings availal	ple
Ě	The The page	E C						pe 1 □ Ye	utopsy erformed? s 22No	death?		18
Vital	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				of Death (Check on	ly one)			
ō	ding Physician: The lav h. After this certificete has funeral director, page 2	2	1 Yes 2X No 27. Manner of Death	1 Inpatie	nt 2 ER/Outpati		Other: 4 Nur	sing Home 5 R			cify)	
on	Attending r death. ector: After by the fune	tlor	1 Naturaf 5 Pending 2 Accident investigation	(Month, Day	Year) Injury		Work? 1 ☐ Yes 2 ☐ N		50 110 W 111 Jul	, 00001100		
Division	To the Hospitel or Attent within 24 hours effer death To the Funeral Director: completely filled in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ury - At home, farm, s	street, factory, of	ffice		n (Street an Town, State		ral Route Number,	
	Hospitel of the top of		29a. Certifier 1 Certifying Phy	ysician: To the best of	of my knowledge, de-		the Aller of the control					
	the Hos hin 24 ho the Fun npletely	edical	(Check only 2 Medical Exam	iner: On the basis of and manner sta	examination and/or	investigation, in	my opinion, death	h occurred at the tin	ne cause(s) ne, date and	and manner as diplace, and due	to the cause(s)	
	To the within To the comple	×	29b. Signature and title of certifier		. [	29c. Li	icense number		29d. Da	te signed (Mont	h, Day, Year)	
)			Darbar	a Illi	lan !	WICI	10005	5770	10	7-23	-06	
	5		30. Name and address of person who o	completed cause of de			iat.	SL	4	10-0 110	well De	2
10	Sta	te.	31. Date filed (Month, Day, Year)		ar's Signature		letow.	7 2/061	10-21	CO. NO	were ist	
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			i icusc	State of Marylan				-	niene a a	
		•	For State Registrar	otate of marytan		ficate of L			2006	35757
			1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea Month		3. Time of Death
	Physicia /Medic Examin	al	JOSEPH N/M/N 4a. Facility Name (If not institution, give			b. City, Town, or	Location of Dea	OCTOBE		06 2:50PM <sup>M</sup>
			2492 HOMESTEAD			WALD			CHAR	
	Funeral Director		5. Social Security Number  6. Social Security Number  1  222-50-7941  Usual Residence of Decedent	7. Age (In yrs. № 2 F 45		f Under 1 Year Ionths Days	Hours Min			rthplace (State or Foreign Country) JTH CAROLIN
	yland	Ì	10a. State 10b. County	10c. Cit	y, Town or Locati	ion				10d. Inside City Limits
	e Mary	ctor	MARYLAND CHAR	LES V	ALDORF	1				1 □ Yes <b>X</b> No
	vith th	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	•
	na 234	eral	2492 HOMESTEAD  11. Marital Status	COURT  12. Was Decedent Ever in U	S. 13. Was		601	Specify Yes or No-	U.S. 1	
980	s 1 and 2 should be filed within 72 hours after death with the Maryland f Heelth and Mental Hygiene. It mans 78 is marked other then "natural", or Itama 23a or 28a-f ahow other traumatic event, the Mautical Examble erminatible notified at	þ	1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Forces?  XXYes 2 □ No If Yes, Give Year or Dates 984 -		es, specify Cubai Yes 2⊠ No	n, Mexican, Puè Specity:	Specify Yes or No- rto Rican, etc.)	Black, Wh	ite, etc.
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121	within ene. then "	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO	NOT use retired,	)		CAMIIDN O	E MAIDODE
	filed Hygie other I		12 17. Father's Name (First, Middle, Last)		SALES	CONSU		ume (First, Middle,		F WALDORF
lan	uld be Aental rked c	To Be	JOSEPH BENNET	T, SR.			CAROL	WALLAC	E	
Maryland	ind 2 sho eith and h 27 is me		19a. Informant's Name/Relationship (1 APRIL MIDDLETO						r, City or Town, State,	
Baltimore,	0 0		20a. Method of Disposition  VS Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	Removal from State	lace of Disposition  ametery, cremate  AND VE	ory`or other place		Date 11-6-06	20c. Location - City of CHELTEN	
Balti	permit. Page Depertment Important: It any injury o		21. Signature of Funeral Service Ligen	see MOO	A79 22. N.	ame and Addres	s of Facility FUNERA	L SERVI	CE, P.A.	
	Physician		23a. Part1. Enter the disease, or companies tock, or heart failure. List only Immediate Cause (Final disease or condition	olications had caused the deat one cause on each tine.	n. Do not enter to	PLATA he mode of dying	MARY g/such as cardia	<del>LAND 2</del> ac or respiratory an	<del>0 6 4 6</del>	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	0.				7/2013
7		Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a conseq	uence of):	01477	1			
v O	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):					
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ds, P.	ires that t signed by d be deta	٥	Part II. Other significant conditions	ontributing to death but not res	ulting in the unde	rlying cause give	en in Part I.			to the cause of death?
COL	w require been si should t	lete	***					24a. Was a		autopsy findings available
of Vital Records,	n: The law icate has r, page 2 :	Completed						autop perfor 1  Yes	sy prior to death? 2 No 1 \( \text{Ye} \)	completion of cause of
ž	Physician: T r this certificat ral director, pa	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ED/Outpationt	3□ DOA Othe	_	eath (Check only or		
on of	ding Phy h. After this funeral d	tlon: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at Nursing		ence 6 Other (Sp ow intury occurred	ecity)
Division	l or Attanding effer death. Director: After I in by the fune	Certification:	3 Suicide 6 Could not be determined	!				28f. Location (S City or Tow	street and Number or I m, State)	Rural Route Number,
	To the Hospital or Attending Phys within 24 hours effer death.  To the Funaral Director: After this completely filled in by the funeral di	edical C	29a. Certifier (Check only one) Certifying Ph	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death or tion and/or inves	ccurred at the tim tigation, in my op	ne, date and place pinion, death occ	ce, and due to the courred at the time, of	cause(s) and manner a date and place, and di	as stated. ue to the cause(s)
	To th within To thi compl	Me	29b. Signature and title of certifier			29c. License	number	-	29d. Date signed (Mor	nth, Day, Year)
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	941					LO UNI	y CHZ	warn	11-1/ NE NO	20602
	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 3 20	32. Registrar's Signa	iture	2.42				

06-08165 В

#### Please Type or Print in Black Indelible Ink

uno Brunozzi		State of Maryland / [	Department of F Certificate of D			a No. 200	0 0 5 7 5
Physici		Registrar 1. Decedent's Name (First, Middle,Last)		_	2. Date of Deat		3 Time of Death
ledical Exami ෴	iner	Bruno BRUNOZZI			Month October 29	Day Year 9, 2006	1737 hrs
		Facility Name (if not institution, give street and number)     S6 Broadway Street		City, Town, or Loc	ation of Death	4c. County of Death Washington	1
Funeral		· · · · · · · · · · · · · · · · · · ·			f Under 24Hrs 8. Date of Bird		thniana (State or Eoroiga
Director					Hours Min. 4-25-5	Co	untry)  Italy
au's			c. City, Town or Location				10d Inside City Limits
ž	ř	Maryland Washington	Hagerstow	n			1 X Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once	rector	10e. Street and Number		Of. Zip Code	10	g. Citizen of What Cou	ntry?
th the N 23a or notified	ā	56 Broadway Street		21740		Italy	
h with	Funeral	11. Marital Status  1 Never Married 2 X Married Armed Forces?	ver in U.S. 13. Was D	ecedent of Hispan	ic Origin? (Specify Yes or No- exican, Puerto Rican, etc.)	14. Race - Ameri White, etc.	can Indian, Błack,
or death w	Fun	1 Yes 2x	No				
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and hanel Hygienie filed hand and the filed beautiful, or items 23a or 28a-f she transmite event, the Medical Examiner must be notified at once	by	Widowed 4 Divorced If Yes, Give Year or Dates  15 Decedent's Education (Specify only highest grade completed)  16 Decedent of the property of the propert		es 2 X No s	Give kind of work done	Specify: Wh:	
72 hou "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most	of working life. DC	NOT use retired)	Commercia	
0036 within 72 iene rer than '	ηdμ	12 0	Carpe	nter		Construct	
5-00; lied with Hygiene I other th	- 1	17. Father's Name (First, Middle, Last)			Nother's Name (First, Middle, N		
21215-0036 Muld be filed within 7 Mental Hygiene marked other than	Be	Fernando Brunozzi			aria Avincola		
D 2 shoul and M 7 is m	7	19a Informant's Name/Relationship (Type, Print )			d Number or Rural Route Num		
and 2 shou lealth and ? tem 27 is retraumatic		Hye Young Yi Brunozzi - Wife	20b. Place of Dispositio	Hickory I		own, Md. 2	
nore, MD ages I and 2 sh ent of Health an		1 Burial 2 X Cremation 3 Removal from State		• •			
_= <u>- = = = = = = = = = = = = = = = = = =</u>		4 Donation 5 Other Specify. 21 Signature of Funeral Service Licensee	Hagerstown	Cremato	ry   11/2/06 Facility Minnich Fu	Hagerstown	, Maryland
Balt permit Depart Import		13.1.200 B. C.		E. Wilso		neral home rstown, Md.	21740
Physician		23. Fart I. Enter the disease, or complications that caused the failure. List only one cause on each line.					Approximate Interval
/Medical Examiner		Immediate Cause (Final disease a. Upper Gastrointes	stinal Hemorrhage o	omplicating C	irrhosis		Between Onset and Death
		or condition resulting in death)  Due to (or as a consequence)	uence of):				
	7	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of the control of th	ience of):				
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cuted und transit	Exa	events resulting in death) Last Due to (or as a consequ	uence of):				
exe an a	ical	d. UNPENDED AMENDED				***	
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be exwitin 24 hours after death. The How site of the the Third Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	Medical	IF FEMALE: 23c. If yes, outcome	of pregnancy			23d Date of delivery	
Box 6870  The death certification the attending place in the attending place is the second contract of the second	an/I	23b. Was decedent pregnant in the past 12 months?	2 Fetal	death 3	Ectopic pregnancy	1	Day Year
eath c atten for us	Physician/	1 Yes 2 No 9 Unknown g Unknown	ne of death 5 Other	(Specify)			
D.O. Be that the detached		Part II. Other significant conditions contributing to death be	ut not resulting in the und	erlying cause giver	n in Part I. 23e Did to	bacco use contribute to	the cause of death?
, P.O.	d by	Alcohol Abuse			1 Yes	2 No 3 Prob	pably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law require and a fairer death. After this certificate has been sited in by the funeral director, page 2 should be	Completed	DinBetes	*		24a Was a		topsy findings available
Reco The law icate has	mp	12011-16-16-3	<del></del>		autop	med? death?	completion of cause of
tal Re rian: The certificate ector, page		25. Was case referred to medical		26.Place of I	1 Yes 2	No 1 Ye	s 2 No
Vital   ysician: this certifi director.	To Be	examiner?  1 Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatient 3	DOA Oth	er Nursing Home 5	Residence 6 🗸 Other	: Scene
n of N ling Phy After tl funeral	n: T	27. Manner of Death 28a Date of Injury (Month, Day, Year)	28b. Time of Injur	y 28c. Injury at	Work? 28d Describe h	ow injury occurred	
sion ttend death ctor:	atio	1 Natural 5 Pending Investigation		1 Yes	2 No		
Divis pital or At ours after d teral Direc	Certification:	Suicide Could not be	y - At home, farm, street, f	actory, office build	ing, etc. 28f Location (S or Town, St	treet and Number or Ru	ral Route Number, City
ospita hours ineral y fille		4 Homicide determined (Specify) 29a Certifier - Continue Physics Table 1					
Divisior  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	lical	Certifying Physician: To the best of my kir (Check only one) 2 Medical Examiner: On the basis of examin					
To I To I	Medical	and manner stated.  29b. Signature and title of certifier		29c. License nu		29d Date signed (Mor	
		()		O.C.M.E		October 30, 2006	
		30. Name and address of person who completed cause of deal	th (Item 23a)			2, 200	
4-4		Jack Titus MD. Deputy Chief Medical Exa	•	Street, Baltimo	ore, MD 21201		
S	tate	31. Date filed (Month, Day, Year) 32 Registrar's 32 Registrar's	Signature	1.			
Regis	trar	001 3 1 2000   Destruct	1 B. Apart				
DHMH 17 Rev 1/2	2001	*	ORIĞINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year October Karrenton Gordon Chandler 4045AM /Medical 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctors Hospital Lanham Prince Georges 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F 577-74-2742 **Director** 53 06/21/1953 DC Usual Residence of Decedent la or 28a-f show t be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince Georges Bowie Director XXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11402 Trillum Street 'natural', or items 23a dical Examiner must b 20721 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Many Injury or other traumatic event, the Monee. College (1-4or 5+) Fire Fighter Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grady Gordon Butler Thelma Rotay Chandler 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruby Chandler/ Wife 11402 Trillum St. Bowie,MD 20721 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 P 4 Donation 5 Other (Specify) 3 □Removal from State 10/30/06 |Suitland, Maryland Lincoln Mem.Cem. 21. Sign of Funer Service License 22. Name and Address of Facility Taylor's Funeral Home 1722 North Capitol St.NW Washington, DC 236. Part1. Enter the disease, or complifications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the vause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner nstridium Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) that the death certificate be executed burial-trai Due to (of as a consequence of) attending physician for use as the buria Bleeding Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the a 9 Unknown sate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2 No Physiclan: funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? After 1 28d. Describe how injury occurred or Attending (Month, Day Year) 1 Natural 5 | Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a Hospital 1 Descertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

completely State

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division or Vital Records,

31. Date filed (Month, Day, Year) 32. Registrar's Signature

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

(Check only

29b. Signature and title of certifier

8118 GOOD LUCK KOAD

29c, License number

29d. Date signed (Month, Day, Year)

LANHAM, MA 20706

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? [] [ For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** HAROLD REDMOND COAN OCTOBER 23, 2006 12:52A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1601 DEWITT AVENUE CAPITOL HEIGHTS PRINCE GEORGES 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**XX**M 2□ F Yrs. Director 63 257 62 1835 JUNE 22, 1943 SOUTH CAROLINA Usual Residence of Decedent the Maryland 10a State 10c. City. Town or Location 10b County 10d. Inside City Limits 28a-1 shov other traumatic event, the Medical Exercine must be notified at Director XXYes 2 No MD PRINCE GEORGES CAPITOL HEIGHTS 10e. Street and Number 10g. Citizen of What Country? with ō Items 23a 1601 DEWITT AVENUE 20743 UNITED STATES is 1 and 2 should be filed within 72 hours after death if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23 Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify: Specify: BLACK 3 ☐ Widowed AXDivorced Year or Dates: 1965-67 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12TH WAREHOUSE SUPERVISOR SAFEWAY FOODS permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 Is marked othe any injury or othar traumatic evant, 2002. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ S. CONRAD COAN P. WILHELMINA REDMOND 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HYATTSVILLE, MD 20784 6905 BUCHANAN STREET SHIRLEY WRIGHT / SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) METROPOLITAN CREMATORY 10/28/06 ALEXANDRIA, VA 21. Signature of Funeral Service 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or rear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** YEARS GASTROINTESTINAL STROMAL TUMOR /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 980 If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy þ in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes **2**√T√No 1 Tyes or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: 4 Nursing Home XX Residence 6 Other (Specify) Hospital: Certification; To 1 Yes XXNo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred XNatural 5 Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated within 2 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 4Myrem D23308 OCTBOER 25, 2006

State

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

of Vital Records,

Division

VICTOR M. PRIEGO, M.D. 31. Date filed (Month, Day OCT 2

30. Name and address of person Completed cause of death (Item 23a) (Type, Print)

6420 ROCKLEDGE DRIVE, SUITE 4100 BETHESDA, MD 20817

		•	For State Registrar	State of Ma		partme <i>ertifica</i>			nd Me		giene Reg. No.	2006	35761
	Physicia	an	1. Decedent's Name (First, Middle, La	•					2	Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al .		CHRUSTY						SCT	24	500G	6:06 8 M
	Examin	er	4a. Facility Name (If not institution, give		Have A			Location of			4c.	County of Death	
			5. Social Security Number 6.5		(In yrs. last birtho		er 1 Year	If Under 2		Date of Birt	<u> </u>	House	
	Funeral Director	1		10XM 2□F	80 Yrs	Months		Hours	Min.	Date of Birt (Month, Day ug 29,	Year)	GOL COL	place (State or Foreign untry)
			Usual Residence of Decedent						A	ug 29,	192	6 Ohio	
	how		10a. State 10b. County		10c. City, Town o	r Location							10d. Inside City Limits
	Be-f	cto	Maryland Howard		Ellicott	City							1 □ Yes 2X□ No
	vith th	Die	10e. Street and Number				ip Code					zen of What Cou	untry?
	s 23s	erai	9041 Overhill Dri	7E 12. Was Decedent E		210			i-0 /C		USA	14. Race - Amer	inna ta dina
	within 72 hours after deeth with the Maryland ene. Than "natural", or Items 23a or 28e-f ehow he Medical Examirar must be molified at	Funeral Directo	11. Marital Status  1 ☐ Never Married 2 ☒ Married	Armed Forces?		If Yes, sp	ecify Cuba	n, Mexican,	Puerto Ric	fy Yes or No- can, etc.)		Black, White	
036	urs al	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 1		1 🗆 Yes	2 💢 No	Specify:				Specify: Whi	te
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Baltimore, Maryland	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Items 23a or 28e-f show amy injury or other traumatic event, the Medical Examinating that indiffied all Andres.				1								p Code)
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			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused to one cause on each line	the death. Do not	enter the mo	de of dying	g, such as c	ardiac or r	espiratory ar	rest,		Approximate Interval Between
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	/Medical Examiner		resulting in death)		consequence of):								
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Box	th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		3 ☐Ectopic	pregnancy				2	23d. Date of deliv	•
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5		To B	examiner? 1 Yes 2 No	Hospital:	t 2 ER/Outpa	atient 3 🗆 🖸	Othe	05		Check only o		S □Other (Spec	(6.1)
o	et or Attending Physician: s efter death. il Director: After this certifica od in by the funeral director.		27. Manner of Death	28a. Date of Injury (Month, Day	/ 28b. Tim		28c. Injury Work			d. Describe h			ny)
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Division	r Atte	Certification;	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined		ry - At home, farm (Specify)	, street, facto	ry, office		28	f. Location (S City or Tox	Street and	d Number or Ru	ral Route Number,
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	공 <del>+</del> 필 등	edical	29a. Certifier 1 Sertifying P (Check only one) 2 Medical Exa	hysician: To the best of miner: On the basis of	examination and/o	leath ceeurs or investigatio	d at the tim in, in my of	ne data and pinion, deat	placa, an	d due to the a at the time,	date and	and manner ac- place, and due	etated. to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stat	ed.		9c. License				_	e signed (Month	
	F 3 F 8								<b>'</b> +	1		-	
1	1)_		30. Name and address of person who	completed cause of de	ath (Item 23a) (Tu	ne Print)			,			4	200
(2)	00		DAVO O, NYA	ON MUCH	10724	UTTIR	PATI	SKONT	pm	curry	C	SLUMBIA	2006 mo 20044
1	Sta		31. Date filed (Month, Day, Year)	2006 32. Registra	r's Signature	4	AND DESCRIPTION OF THE PROPERTY OF THE PROPERT						, , , ,
	Regist	ar	UCT 2 7	Z006	me to	Lineah	3 6						

	1	For State Registrar	State	of Maryla				ealth a Death	and M	ental H	ygiene Reg. No	20	06	3576
Physician /Medica		1. Decedent's Name (First, Middle Rachel L. Chap								2. Date of E Month 10	Death Da 25		Year 006	3. Time of Death
Examine	r	4a. Facility Name (If not institution Berlin Nursing	& Rehabil	litatio		Be	rlin	Location o				. County o		
Funeral Director		5. Social Security Number  218-40-6178  Usual Residence of Decedent	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs	s. last birthday) Yrs.	If Unde Months	Days	If Under a	Min.		Birth Da <i>y, Year)</i> 27 19		9. Birthp Cour VA	place (State or Foreign ntry)
the Maryland		10a. State 10b. County MD Worce  10e. Street and Number			city, Town or Lo		p Code							1 Mary Yes 2 No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Itam 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic avent, the Medical Examinat must be notified at once.  To Be Commission by Europea Infrared.	runeral Dir	4657 Snow HII1  11. Marital Status  1 Never Married 2 Mar	12. Was De Armed F	cedent Ever in Forces?	U.S. 13.	Ве	rlin		gin? (Spe , Puerto F	cify Yes or N Rican, etc.)	USA	14. Race		can Indian,
nin 72 hours a	Completed by	3 ☑ Widowed 4 ☐ Divorced	If Yes, G Year or t's Education st grade completed	Dates:	16a. Dece	1  Yes  dent's Usi kind of w	ial Occupa	luring most	of workir	ng	16b. K	Specify:	Whi	
d be filed with antal Hygiene ced other that c avent, the	e a	17. Father's Name (First, Middle, Seymour P. La	Last)	(1-4or 5+)	Tea	cher			r's Name	(First, Midd		.001 Sumame		em
tealth and Meter traumati	0	19a. Informant's Name/Relations Deborah Newell	hip (Type, Print)		370	9 Gur	wood	and Numbe	vor Rura	Route Num	Beac	h, V	A 23	456
mit. Pages 1 partment of H sortant: If Ita rinjury or ot		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S  21. Signature of Funeral Service	pecify)	n State	Place of Dispo cemetery, created Aakemie	matory or Chiii	other plac	rd 1	n / 2 0	/2006 Burba	Sno	whil	1	own, State
Physician	4	23a Part1. Enter the disease of shart failure. List Immediate Cause (Final	complications that only one cause on	caused the deceach line.	1	08 Will	11ia: de of dyin	m St. g, such as	, Be	rlin,	MD 2	1811		Approximate Interval Between Onset and Death
The law requires that the death certificate be executed be the standing physicien end page 2 should be detached for use as the burial-transit and the page 2 should be detached for the page 3 should be detached for the page 3 should be detached	dical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. ————————————————————————————————————	o (or as a conse	equence of):									Tees
that the death certific ed by the attanding p detached for use as	Pnysician/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live	utcome of preg birth 2 Pe gnant at time of nown	tal death 3[	∃Ectopic p ∃Other (s						23d. Date Mon		ery Day Year
s been signed by the should be detach	2	Part II. Other significant conditi	ons contributing to	death but not re	esulting in the u	nderlying	cause give	en in Part I.			tobacco		bute to the	ne cause of death?
	Completed										opsy formed?	d d	Vere auto rior to co eath? Yes	psy findings availabl mpletion of cause of 2 No
A 20 1	0 00	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3 □ D	OA Othe		of Death	<i>(Check only</i> ne 5 □ Re	one)	6 □Othe	r (Specif	iv)
£ 5 5 .	Certification;	27. Manner of Death  Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could	28a. Date (Mo	of Injury onth, Day Year)	28b. Time o Injury	f M	28c. Injury Work 1 🗀 `		No 2	8d. Describe	e how inju	ry occurre	ed	
To the Hospitel or Attanding within 24 hours effer death. To the Funeral Director: Affei completely filled in by the funeral Director.	al Certii	4 Homicide determ	buil	ce of Injury - At ding, etc. (Spec ne best of my kr	oify)	h occurred	l at the tim	ne, date and	d place, a	City or T	own, State	e)	nar as s	A Route Number,
To the Ho within 24 h To the Fur completely	Medical	(Check only one) 2 Medical 29b. Signature and title of certifie	and ma	basis of examir nner stated.	nation and/or in	vestigatio	n, in my op Ic. License	number	th occurre	ed at the time	29d. Da	d place, a	(Month,	Day, Year)
A 10		30. Name and address of person	who completed car	use of death (Ite	- 1	Print)	Do	. 85 T	ン <u>()</u> こ	1	10	10	)(0	6 19944
State Registra		31. Date filed (Month, Day, Year)		Rysistrar's Sign	nature	ex li	gleu	7	the	ial +	gica	) <sub>(</sub> N	C 1	1149

		For State Registrar	State of Maryla		partment of F e <i>rtificate of I</i>		-	giene2 (	006	35763
Physic		1. Decedent's Name (First, Middle, L Eleanor Madel					2. Date of De Month	Day	Year	3. Time of Death
/Med Exam		4a. Facility Name (If not institution, g.	ive street and number)		4b. City, Town, o	Location of Deat	Octobe		2006 ity of Death	12:28 P M
Funera		9603 Sutherland 5. Social Security Number 6.	Road Sex 7. Age (In yrs	. last birthda	Silver y) If Under 1 Year Months Days	Spring   If Under 24 Hrs   Hours   Min.	(Month, Da	th y, Year)	Coul	place (State or Foreign
Directo	r	Usual Residence of Decedent		91 ".			April	11, 191	5 Rh	ode Island
aryland hhow	١,	10a. State 10b. County		ity, Town or						10d. Inside City Limits
the Ma	ecto	Maryland Montgor	nery	Silv	er Spring			40. 000		1 ☐ Yes 2 No
deeth with the Maryland me 23a or 28a-f show rmust be coulfied at	al Dir	9603 Sutherland	l Road		10f. Zip Code 20	901		10g. Citizen o	JSA	ntry r
ITE, INIAL FIGURE X 1X 13-0030 s 1 and 2 should be filed within 72 hours after deeth with the Marylan If Health and Mental Hygiene. Item 27 is marked other than "natural", or Itams 23s or 28s-f show other traumatic avent, if a Medical Event an initial to notified at	by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ②Yes 2 □ No If Yes, Give Year or Dates: 1943		B. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ XNo	ispanic Origin? (S in, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Ri Bi	ace - Ameni lack, White, cify: Wh	
Mary Idilia Z 12 13-0050 12 should be filed within 72 hours after h and Mental Hygiene. 7 is marked other than "naturel", or its fraumatic event, its Medical Events.	Completed	15. Decedent's (Specify only highest g	Education rade completed) College (1-4or 5+) 5+	(Gi	cedent's Usual Occup ve kind of work done DO NOT use retired	during most of wo.	_	16b. Kind of United Armed	Stat	es
d be filed anta! Hygi	Be C		st)				me (First, Middle			
yidi ould be i Menta warked	ToB	Patrick F. Cases					lget M.			
C, Mar I and 2 sh tealth and im 27 le m ther traum	į	19a. Informant's Name/Relationship W. Doris Poole/			iling Address <i>(Street)</i> 3 Sutherla					
permit. Pages 1 and Department of Health Important: If Item 23 any Injury or other to		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			position (Name of rematory or other place eaven Cemeter		Date cober 30 2006	20c. Location		own, State
Departition of the post of the		21. Signature of Funeral Service Lic	ensee		Francis Adde	ss collins	Funera	1 Home	Inc.	, MD 20901
		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the deay one cause on each line.							Approximate Interval Between
Physiciar /Medica	_	Immediate Cause (Final disease or condition resulting in death)	a. Lymphoma							Onset and Death  1 Month
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ificate be executed g physicien and as the burial-transit	edical	•	d							
Centing Iding	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death	B Ectopic pregnancy Dither (specify)			1	Pate of deliver	ery Day Year
wrequires that the death been signed by the attershould be detached for un	۵	artii. Other significant conditions	contributing to death but not re	sulting in the	underlying cause giv	en in Part I.		obacco use co Yes 2□No		he cause of death?
TECO The law rec te hes been	Completed	-						osy ormed?	prior to co death?	opsy findings available impletion of cause of
VICAL ician: 1 certifical ector, p	BeC	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes ath (Check only		1 🗆 Yes	2 No
Of V Physic this ce at dire	ို	1 ☐ Yes 2 🛣 No	Hospital: 1 Inpatient 2	<del></del>		4   Nursing P	lome 5 🙀 Resi			<b>'y</b> )
nding I nding I th. : After e funer	ation	27. Manner of Death 1 SNatural 5 Pending 2 Accident investigate	28a. Date of Injury (Month, Day Year) on	28b. Time Injury	/ Wor	/at k? Yes 2∐No	28d. Describe	how injury occi	urred	
DIVISION OF VILLI INC.  To the Hospital or Attending Physician: The lav, within 24 hours effer death.  To the Funeral Director: Affer this certificate hes completely filled in by the funeral director, page 2.	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		home, farm,	street, factory, office		28f. Location ( City or To		nber or Rura	al Route Number,
a Hospit 124 hours ia Funera letely fille	edical	29a. Certifier 1  Certifying F (Check only one)	Physician: To the best of my kraminer: On the basis of examinand manner stated.	nowledge, de nation and/or	ath occurred at the tin investigation, in my o	ne, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) and r date and place	manner as s	stated.  the cause(s)
To th. To th comp	M	29b. Signature and title of certifier	) .	<del></del>	29c. Licens			29d. Date sign		
15		1 Wh	1em			24571		Octob	cr 26	, 2006
		30. Name and address of beson when Jan Weiner				m				
	tate	31. Date filed (Month, Day, Year)	32 Registrar's Sign	Tature	Cardo	1010				
Regis	strar	OCT 27	2006 France J	J. A	DESCRIPTION OF THE PERSON OF T					

20a. Method of Disposition   Surface   Disposition   Disposition   Surface   Disposition   Dispositi				Please I	ype or Print							ible.		
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Catherine  Catherine							Certifica	te of Dea				00		
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The Capt   The Capt				216-14-9115	111 - 472 -		Months			(Month, Day,				əign
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Marion Hitchens		th with t 23a or 2	ai Dir		ane		10f. Z			10			itry?	
Marion Hitchens		ems erre	Iner	11. Marital Status	12. Was Decedent Ex Armed Forces?	ver in U.S.	13. Was Deci	edent of Hispan	nic Origin? (Speci exican, Puerto Ri	fy Yes or No- can, etc.)				
Marion Hitchens	0036	ours afte ral', or It	þ		If Yes, Give	)								
Marion Hitchens	15-	in 72 h n "natu teolical	oletec	(Specify only highest grade	e completed)		(Give kind of w	ork done durina	g most of working	1	6b. Kind of I	Business/Ind	dustry	
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Compared to the control of the con	ē,	f Heal		20a. Method of Disposition	, , , , , , , , , , , , , , , , , , , ,	20b. Place of	Disposition (Na	ame of	Dat	te 2	Oc. Location	- City or To	wn, State	_
Compared to the control of the con	Ë	Page: ient o nt: if ry or	i		emoval from State				10/28	/06	Salis	shurv.	MD	
Agronomatic properties of the control of the cause of the control of the cause of the control of the cause of the control of the cause of the control of the cause of the cause of the control of the cause of the ca	Balti	permit. Departm Importa eny inju		21. Surature in uneral Survice License	00		<sup>22</sup> Holla	nd Address of	Facility neral Ho	me Proi	essio	nal As	sociatio	on .
The first and the past 12 months?    The past 12 months?   23c. It yes, outcome of pregnancy   23c. It yes, outcome of pregnancy   1   1   2   Felal death   3   Ectopic pregnancy   1   1   2   Felal death   3   Ectopic pregnancy   1   1   2   Felal death   3   Ectopic pregnancy   23c. It yes, outcome of pregnancy   1   1   2   Felal death   3   Ectopic pregnancy   3   2   2   2   2   2   2   2   2   2		/Medical Examiner	er	shock or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	IOXIA consequence	of):	de of dying, su	ch as cardiac or (	espiratory arre	st,		Approximate Interval Between Onset and Death	
25. Was case referred to medical axaminer?  1   Security at work?  1   Security at suit of the control of the c	8760,	ate be executed hysiclan and the burial-transit	20	triat initiated events	Due to (or as a	consequence (	of):							
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Address of Death    State	Reco	The law recate has bee page 2 shor	Complete	·						autopsy perform	egl?	death?	- 1	ible of
Address of Death    State	/ita	cien: ertific	Be	examiner?	In an ideal.				Place of Death (	Check only one	)		Accord 13	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  M. THIMMALAYAMA BY BEASTERN SHALE PK, SALISBURY MD 2 (804).  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		ing Physi After this c luneral dir	ion: To	27. Manner of Death  1. Natural 5 Pending	28a. Date of Injury	28b. 1	Time of njury	28c. Injury at Work?	28				LIVING.	_
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  M. THIMMALAYAMA BY BEASTERN SHALE PK, SALISBURY MD 2 (804).  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	)ivisio	or Attendative death	ertificat	3 Suicide 6 Could not be	28e. Place of Injur building, etc.	y - At home, fa (Specify)				f. Location (Str City or Town	eet and Num State)	ber or Rura	l Route Number,	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  M. THIMMALAYAMA BY BEASTERN SHALE PK, SALISBURY MD 2 (804).  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	_	Hospital Puneral Funeral		(Check only 2 Medical Exami	ner: On the basis of e	examination and	, death occurred	d at the time, da n, in my opinion	ate and place, an	d due to the ca at the time, da	use(s) and m	nanner as st	ated. the cause(s)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  M. THUMMALAYAWA BY BEASTERN SHALE PK, SALISBURY MD 2 (804).  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		o the ithin ( o the comple	Mec		and manher state	eu.	29	c. License nun	nber	29	d. Date sign	ed (Month.	Day, Year)	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature 34. SHIZE DE, SALISBURY MD 2 (804)		10 N		Mahali	11.7	111		D-m	GOTIT		10/2-	·be		
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State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		No		M. THIMAMACAY	AFFA 61			SHIM	E PK, S	ALISIS	KY.	110	2/804.	
VOI & V ZUUD   MA M M		Sta Registr				's Signature	1. 0							

ORIGINAL

Please Type or Print in Black Indelible Ink Tyrone T. Chambers, Jr. State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Amend#5, PenFHPCC10-27-06cm Certificate of Death Reg. No. Pkysician/ Decedent's Name (First, Middle,Last) 2. Date of Death Month Day October 12, 2006 **Medical Examiner** Chambers 0615 hrs Tyrone Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death southbound Route 4 past Walters Lane Forestville Prince George's 5. Social Security Number 6 Sex **Funeral** 7, Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9 Birthplace (State or Foreign 579-92-6808 Director Months Days Hours Min 1 X M Sept. 23, 1974 Wash., DC <del>-6848</del> Usual Residence of Decedent 10a. State 10b. County Oc. City, Town or Location 10d Inside City Limits 28a-f shov 1 X Yes 2 No permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fire m 27 is marked other than "natural", or items 23a or 28a-f she rijury or other reaunatic event, the Nedfeal Examiner must be notfited at once rijury or other reaunatic event, the Nedfeal Examiner must be notfited at once Md. PG District Heights rector 10e. Street and Number 10f. Zip Code 10g Citizen of What Country ā 6608 Merritt St. 20747 United States Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 1 X Never Married 2 Married Armed Forces? White etc. Yes 2 X No 3 Widowed Divorced If Yes, Give Year Yes 2 X No specify. SpecifyBlack 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ed Elementary/Secondary (0-12) College (1-4 or 5+) Complet Baltimore, MD 21215-0036 Custodian Private 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) æ Tyrone Chambers Joanne Payne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6608 Merritt Street
District Heights, Md. 20747 Tyrone Chambers Sr./father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify Resurrection Cem. 10/20/06 Clinton, Md. Signature of Funeral Service Licenses 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 Physician Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Between Onset and /Medical a Multiple Injuries Death Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of). (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and sician/Medical UNPENDED attending physician or use as the burial AMENDED The law requires that the death certificate be Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Day past 12 months? 2 Month Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown Phy Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other4 Inpatient 2 ER/Outpatient 3 DOA After this Nursing Home 5 Residence 6 ✓ Other Scene ۵ 1 Yes 2 28a. Date of Injury (Month, Day Year) Oct 12, 2006 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Pedestrian struck by auto(s) 1 Natural 0608 hrs 5 Pending 1 Yes 2 V No 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc Location (Street and Number or Rural Route Number, City 3 Suicide Could not be within 24 hours a determined (Specify) Major Road / Highway southbound Route 4 past Walters Lane, Forestvil 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ny O.C.M.E. October 13, 2006 cash 30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar DHMH 17 Rev 1/2001 **OCME 2006** 

			1 - For State Registrar	State of Mar		artment of H			iene g. No.2 () (	)6	357	66
			1. Decedent's Name (First, Middle, Last	)				2. Date of Deal Month		Year	3. Time of	Death
	Physici /Medio	_	Rosita Simmons	Collins				10	19	06	8:20	P M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Dea	th	4c. County of			
			Southern Maryland			Clinton					eorge'	
	Funeral			TH OFFE	In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Day,	Year)	Coun	lace (State of try)	r Foreign
	Director		242-84-5847 Usual Residence of Decedent	55				10 04	51	NC		
	yiand		10a. State 10b. County	11	Oc. City, Town or Lo	ocation				11	0d. Inside Cit	y Limits
	Mar Mar	ţ	MD Prince (	George's	Fort Was	shington					1 <b>∦</b> Yes	2 🗌 No
	or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	hat Coun	itry?	
	23a	la La	3303 Lumar Drive			2074	4		United	Sta	tes	
	e Les	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? ( n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		- Americ	an Indian, etc.	
36	s afte	by Fi	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates:		1 ☐ Yes 2 📉 No	Specify:		Specify:	B1ac	k	
Ş	72 hours atter death with the Maryland naturel', or Iteme 23a or 28e-f ehow dical Exandiner Dust be motified at	ba b	15. Decedent's Edu		16a Dece	dent's Usual Occupa	ation		16b. Kind of Bus	siness/Inc	dueto.	
	in 72	Completed	(Specify only highest grad	le completed)	(Give	kind of work done of DO NOT use retired	during most of wo	orking	TOD. KING OF BUS	311102271110	lustry	
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ğ	it Hygid other	BeC	17. Father's Name (First, Middle, Last)					me (First, Middle, I	Maiden Sumame	9)		
<u>lar</u>	should be ind Mental marked o	ToE	Wilford Simmons				Marie	Mitchell	L			
Maryland 21215-0036	2 sho and t		19a. Informant's Name/Relationship (T)	vpe, Print)	19b. Maili	ng Address (Street a	and Number or R	lural Route Number	City or Town, S	State, Zip	Code)	
Σ.	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-1 ahow any injury or other freumatic event, Itia Mudical Examination at the multiled at ODGs.		Carlton Collins,			Lumar Dr	ive, Ft.					
Baltimore,	of H of H if ite		20a. Method of Disposition 1 XBurial 2 Cremation 3 F	Removal from State	20b. Place of Dispo cemetery, crei	osition (Name of matory or other place	e)	Date	20c. Location - (	City or To	wn, State	
Ë	Pages ment of h lant: If its jury or of		4 ☐ Donation 5 ☐ Other (Specify)			ns Cemete	-		Cheltenl			
Salt	Depart Import any In		21. Signature of Funeral Service Licens	1/1/		2. Name and Addres						
	00 = 6 Q		Che W. B	more		500 Allen			p Spring	gs, N		
			23a. Patt 1. Enter the disease, or compl shock, or heart failure. List only o	ne cause on each line.	e death. Do not ent	/ /					Approximate Interval Bety Onset and D	ween
	Physician		Immediate Cause (Final disease or condition resulting in death)	a M.	etasta	lack	Sec	est Co	an Ce	2	51.55t 41.5 E	, out.
	/Medical Examiner		rosulting in doubly	Due to (or as a c	onsequence of):							
		J.	if any leading to immediate	b	OUSHGURICH OZI							
	nsit	듣	cause. Enter Underlying Cause (Disease or injury	(3, 40 %)								
<u>,</u>	execu n and al-tra	Examiner	that initiated events resulting in death) Last	c Due to (or as a c	onsequence of):					_		
8760,	icate be executed physician and the burial-transit	cal		d								
9	tificat ng phy as th	Physician/Medical										
Вох	death certific e attending p id for use as	2	230. Was decedent pregnant	23c. If yes, outcome of page 1 ☐ Live birth 2 [	pregnancy	DEctopic pregnancy			23d. Date	of delive	ry	
	the att	sicia	in the past 12 month?  1 Yes 2 100	4☐Pregnant at tim		Other (specify)			Моп	th	Day Y	'ear
P.O.	± > 0	جُ	9 Unknown				S-101					
	8 6 0	þ	Part II. Dther significant conditions co	,	not resulting in the u	nderlying cause give	en in Part I.		acco use contri			
ord	w requir been si should I	ted	Baile pa	(				1   Ye	es 2 No	3 Proba	ably 4	Inknown
ec	hes by	nple.	Anema					24a. Was a autops	y pi	rior to con	osy findings a	available ause of
=	Page 1	Completed						perform 1 ☐ Yes 3	ned? de	eath?	2□ No	
Vita	iclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		104		ath (Check only on	θ)			
Division of Vital Records,	tranding Physician: death. tor: After this certific the funeral director,	၉	1 Yes 2 No	28a. Date of Injury			4 🗀 Nursing	Home 5 Reside			')	
L C	ding After fune	9	1 → Hatural 5 Pending	(Month, Day Y	ear) 28b. Time o	Work	rat (? Yes 2 □ No	28d. Describe ho	w injury occurre	ea .		
isi	or Attending after death. Director: After in by the fune	lica	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury	- At home, farm, str		103 2 0.10	28f. Location (St	reet and Numbe	r or Rura	l Route Num!	her
ο	7 P F C	Certification;	4 Homicide determined	building, etc. (		oo, 120,017, 511100		City or Towr	n, State)		7 10010 7 10111	,,,,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by		29a. Certifier 12 Certifying Phy	sician: To the hest of r	ny knowledge, deat	h prourred at the tim	ia, date and plan	e, and die to the co	ause(s) and man	mor de et	ated	
	a Ho 124 h	edical	(Check only 2 Medical Exami	on the basis of ex and manner stated	amination and/or in	vestigation, in my op	oinion, death occ	urred at the time, da	ate and place, a	nd due to	the cause(s)	
	To the Hospital of within 24 hours at To the Funeral completely filled in	Me	29b. Signature and title of certifier	70		29c. License	number		9d. Date signed			
			· Harry	Herat		500	954	0	cto De	120	106	
)	(8)		30. Name and address of person with or	ompleted cause of deat	(Item 23a) (Type,	Print)	19	v 0 c	MOSe			
	0		Arastoo Yazdawi	MD	16/ ( ~ ce	rga Air	18 3-4	1 3,5,	W();	209	105	
	Sta		Arastoo Yazdayi - 31. Date filed (Month, Day, Year)	32 Registrar's	Signature Sol	11						
	Registi	ar	OCT 24 200	Delen	N. Pope							1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Otho Cosner ctober /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George Doctor's Community Hospital Lanham 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours 1 X M 2 □ F June 4, 1924 236-44-6624 82 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the MedLal Examiner must be notified at 1K Yes 2 No Director Maryland Prince George Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20706 7313 Powhatan Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status 1X Yes 2 No 1948− If Yes, Give Year or Dates: 1954 within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: à 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bus Driver Greyhound Bus Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fi Department of Health and Mental I-Important: If item 27 is marked ott any Injury or other traumatic ever Be 2 should be f and Mental } Earl Cosner Edna Rinker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4814 Nantucket Rd., College Park, MD Shirley E. Adams/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 10/26/2006 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Se Fort Lincoln Funeral Home, 3401 Bladensburg Rd. Brentwood, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chromic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to influentate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 1 Yes 2 No 9∏Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, þ 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 😿 No 2 ER/Outpatient 3 DOA ဥ 1 X Inpatient After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident To the Hospital or Attend within 24 hours after death To the Funeral Director... 6 Could not be 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) prodecla 18442000 23106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) McKemil Abdella, M.D. 6005 Landover Rd., Ste 3, Cheverly, MD 20785 31. Date filed (Month, Day, Year) 32 Registrar's Signature State OCT 2 4 2006 Registrar

			For State Registrar	State of Mary	•	artment of F			iene <sub>19. No</sub> 2 0 0 6	35768
	Physici		1. Decedent's Name (First, Middle, Last)	Elvina The	resa Chai	ruhas		2. Date of Deat Month Octobe:	Day Yeer	3. Time of Death 2:00 P M
	/Medio Examin		4a. Facility Name (If not institution, give s Berlin Nursing	street and number) Center		4b. City, Town, o		uth	4c. County of Deat	h
	Funeral Director		5. Social Security Number 6. Sex 579–32–5457	7. Age (Ir	n yrs. last birthday) 7 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		Year) Co	hplace (State or Foreign unitry) LSh. DC
	e Maryland 3a-f show	Director	MD. 10b. County Anne Arr		Oc. City, Town or Lo		rills			10d. Inside City Limits 1 1 Yes 2 □ No
	th with th		10e. Street and Number 2011 Huntcliff Di	rive		10f. Zip Code	1054	10	0g. Citizen of What Co USA	untry?
920	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show tha Madical Examinar must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	r in U.S. 13.	Was Decedent of H If Yes, specify Cub. 1 ☐ Yes 2 No		Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
21215-0036	within 72 ho ene. than "natur he Medical.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of w	orking	16b. Kind of Business	Industry
aryland 2	ould be filed Mental Hygi arked other atic event,	To Be Co	17. Father's Name (First, Middle, Last) Unknown		, 500	recury		ame (First, Middle, Mosephine (	Maiden Surname)	
Baltimore, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itema 23a or 28a-1 show emportant: other traumatic event, the Macital Examinar must be notified as QDCs.		19a. Informant's Name/Relationship (Ty,  Tina Dorsey - Dau  20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	ghter	2011 20b. Place of Disponsion Commetery, cre		ff Drive	Gambril Date 23-06	. City or Town, State, 2 ls, Marvlar 20c. Location - City or rownsville	13 21054 Town, State
Baltin	permit. P Departme Importan eny Injuri 2000.	eral Home ie, Maryla	-							
1	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	est,	Approximate Interval Between Onset and Death					
8760,		dical Examiner	Saquardially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury that initiated events resulting in death) Last	Due to (or as a co						
P.O. Box 68	The law requires that the death certificate be executed tees been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	y		23d. Date of del Month	ivery Day Year
Ś	w requires that been signed to should be deta	Ď.	Part II. Other significant conditions cor	ntributing to death but n	ot resulting in the u	inderlying cause giv	ven in Part I.		oacco use contribute to es 2 ☐ No 3 ☐ Pr	1
al Record		Completed						24a. Was ar autops perforn 1 🗆 Yes 2	y prior to	topsy findings available completion of cause of
of Vital	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1  Yes 2 No	fospital:	2 ER/Outpatie	nt 3 DOA Ott	or /	eath Check only one Home 5 Reside	ence 6 Other (Spe	cify)
ion o	After fune	ation:	27. Manner of Death   Natural 5   Pending investigation	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	Wo	y at rk? Yes 2 ∐No	28d. Describe ho	w injury occurred	
Division	≥ # # =	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (5	Specify)			City or Town		
	To the Hospitel within 24 hours of To the Funeral completely filled	Medical	29a. Certifier (Check only one)  Certifying Physical Examination (Check only one)	sician: To the best of m ner: On the basis of ex- and manner stated	amination and/or in	th occurred at the time to the time time to the time to the time time to the time time to the time tin	me, date and place opinion, death occ	ce, and due to the ca curred at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	Te se men	₹	29b. Signature and title of centitier	de.	1	29c. Licens	1856 1		9d. Date signed ( <i>Mont</i> )	
1	-(6)		30 Name and address of person who co	empleted cause of death	h (Item 23a) (Type	Print) Count	el Henho	un Feur	10/19/00 ut Islands	Ct 19944
	Sta Registi		31. Date filed (Month, Day, Year)  OCT 2. 0 2006	2. Registrar's	Signature	lis.		/		•

06-08047 James Curles

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene

Amend #1 Per ME G862 12/22/06 The True ME

2006 35769

			TCI TIL G	002 1	Certific	ate of	Death			R	eg. No.		
	an/	Decedent's Name (First, Midd							2.	Date of Dea Month	ath Day	Year	3. Time of Death
ledical Exami	ner	John Matson Cu		mes	Masto		urles			October 2	26, 2006		0500 hrs
)		4a Facility Name (if not institution 1735 N. Salisbury Blv		imber)		41	o. City, Town, or L Salisbury	ocation of	Death			ounty of De Dmico	eath
Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birt	hday)	If Under 1 Year	If Under		8. Date of Bi	rth (MM/DD/	<b>YYYY</b> ) 9.	Birthplace (State or Foreign Country)
Director		252-06-3105	1 X M 2 F	48		Yrs	Months Days	Hours	Min.	02/16	/1958		Georgia
×	[	Usual Residence of Decedent  10a State 10b. County		1400	. City, Town	es l'englis							I do a la de Con I anno
ow any				100	-		11						10d. Inside City Limits  1 Yes 2 X No
faryland 28a-f show 1 at once.	ģ	Georgia Mitc	nell		Meig	<del>5</del>	10f. Zip Code			1.			
ine ne	Director	8323 Georgia	Highway 1	11			31765	5			I0g. Citizen USA		ountry?
with the mis 23a	Funeral	11. Marital Status	12. Was Dec		r in U.S.		Decedent of Hisps, specify Cuban,				)- 14.		merican Indian, Black,
or ite	Ē	1 Never Married 2 X M	1X Yes	2	No				rueito Ri	can, etc.)		White, et	
s after ral", riner	à		orced If Yes, Give Yea or Dates:				Yes 2 X No					ecify:	white
hour natu		<ol> <li>Decedent's Education (Spe Elementary/Secondary (0-12)</li> </ol>					s Usual Dccupations st of working life				16b Kind	of Busine	ess/Industry
036 thin 72 ne. • than " ledical	Completed	12	- College (	1-4-01-51)	S	meri	ntendent					C E	rilter
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21215-0036 uld be filed within 72 Mental Hygiene. marked other than " e event. the Medical.	Be (	Joseph A. Curl	es Sr.					Edr:	ice E	Taye M	oblev		
2121; hould be fill nd Mental It is marked ntic event.	2	19a. Informant's Name/Relations	ship (Type, Print)		19	b. Mailing	Address (Street						tate, Zip Code)
a ar		Rita Curles/wi	fe		1 8	3323	Georgia	High					
ore, M es I and 2 of Health If item 2 her traw		20a. Method of Disposition  1 X Burial 2 Cremation	n 3 Removal fr	om State	20b. Place	of Disposit ory or othe	ion (Name of cemer place)	etery,	[	Date	20c. Loc	ation - City	or Town, State
Pag Pag In or or or	11	4 Donation 5 Other S	_	om otate	Gara	rest ens	Memory		10/30	0/06	Pell	ham,	GA
Baltimore, permit. Pages I an Department of Hea Important: If iter	1 1	21 Signature of Funeral Service		,				af Facility Fune:	cal E	Tome P	rofes	siona	al Association
	1	W. Richard Hollow				5	01 Snow	Hill	Rd.,	Sali	sbury	,MD 2	al Association 21804
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause		aused the	death. Do n	ot enter the	e mode of dying, s	such as ca	rdiac or re	espiratory arr	rest, shock,	or heart	Approximate Interval Between Onset and
Examiner	ì	Immediate Cause (Final disease or condition resulting in death)				scler	otic cardi	ovascu	ılar d	isease			Death
			Due to (or as a	conseque	ence of):								
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a	conseque	ence of):								
	Examiner	Cause Enter Underlying Cause (Disease or injury that initiated	c. Due to (or as a	concoduc	nno of):								
executed an and al - transit		events resulting in death) Last	d	a conseque	ance or).								
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18760, rificate be exe	/Me	IF FEMALE: 23b, Was decedent pregnant in t	23c. If yes,	outcome o	f pregnancy							ate of deli	•
68 certifi nding	ian	past 12 months?	I LIVE I	oirth nant at time			al death 3	Ectopic	pregnanc	У	Mo	onth	Day Year
Box 6 he death cerr the attendii	Physician	1 Yes 2 No 9 Un	known 9 Unkn			Din	er (Specify)						
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cords law requires has been 2 should	Completed									24a Was			e autopsy findings available to completion of cause of
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Vita ysicia his ce direc	o Be	examiner?  1 Yes 2 No	Hospital: 1	Inpatient	2 ER/D	utpatient	3 DOA	Other 4	Nursing I	Home 5	Residence	6 🗸 0	ther: Scene
n of ing Ph After t funeral	n: T	27. Manner of Death	28a. Date (Mont	of Injury h, Day,Year)	28b.	Time of In	jury 28c. Injur	y at Work?	28	8d. Describe	how injury	occurred	
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Division of Vital Records, tat or Attending Physician: The law requir as fairer deal.  In Director: After this certificate has been sited in by the funeral director, page 2 should t	Certification	3 Suicide 6 Cou	ald not be 28e. Place	ce of Injury	- At home, f	arm, stree	t, factory, office bi	uilding, etc	28	Bf. Location (		Number o	Rural Route Number, City
Di spital nours a neral I	Cer	4 Homicide	ermined (Specify)	)									
Division of Vital Records, P.O. Box 6 with Hospital or Attending Physician: The law requires that the death certain to the tuneral Director: After this certificate has been signed by the attendit completely filled in by the funeral director, page 2 should be detached for use	ical	(Oridon diny	hysician: To the beaminer: Dn the basis		_								
To 1 With To t	Medical	29b. Signature and title of certifi	and manner				29c. License						(Month, Day, Year)
	_	-11,	111	-/ -			O.C.M					er 26, 2	
		30. Name and address of perso	n who completed as:	J		MB.							
		Theodore M. King, Jr		_	ical Exam	niner	111 Penn Str	eet, Balt	timore,	MD 2120	1		
S	tate	31. Date filed (Month, Day, Year, NOV 0		epistrar's S		/3				-			
Regis		NOV 0	1 2006	Mague.	J. H.	do	Why)						

			For State	State c	f Maryla	-	artment of H				0.0	0.0.0	05770
	-		Registrar  1. Decedent's Name (First, Middle,	( act)		Cei	rtificate of l	Death		2. Date of Dea	Reg. Ng.	100	3 7 J U
ŀ	hysicia	an					0		2	Month	Day	Year	2:26 PM
	/Medic		4a. Facility Name (If not institution,	Daniel		re	Sr. 4b. City. Town, or	r Location	of Death	Octob		2006 inty of Death	7.20
ľ	Examin	er	313 S. Haven A				Salisbu				10.00	Wicomi	CO
E.	ıneral			S. Sex	7. Age (In yrs	s. last birthday)	If Under 1 Year	If Under		3. Date of Birt	h		place (State or Foreign
	rector		213-22-4699	1 M 2□F	78	Yrs.	Months Days	Hours	Min.	(Month, Day 7/21/19	y, Year) 928		yland
P			Usual Residence of Decedent		140.0								
arylaı	show	_	10a. State 10b. County		10c. C	C - 3						1	0d. Inside City Limits 1 XYes 2 □ No
e M	- 88 - 48	Director	Maryland Wicomi			Sar	isbury						
be filed within 72 hours after death with the Maryland tal Hygiene.	item 27 ie marked other then "netural", or iteme 23a or 28e-f show other treumatic event, II w Mudical Exerciner must be notified at		313 S. Haven Av	e.			10f. Zip Code 21804	ļ			US/	of What Cour A	ntry?
deat	L L	Funerai	11. Marital Status	12. Was Dec	edent Ever in I	U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Or	rigin? (Speci	ify Yes or No-	14. [	Race - Ameno	
after	or it		1 Never Married 2 Marrie		2 <b>X</b> No		1 ☐ Yes 2 XNo	Specify:		iouri, oto.,		Black, White,	
Sunor	ural',	d by	3 Widowed 4 Noivorced	Year or D	Dates:					1		WII.	
721	"net	Completed	15. Decedent's (Specify only highest	Education grade completed)		(Give	dent's Usual Occup kind of work done o DO NOT use retired	durina mos	st of working	,		of Business/In	*
withir	then W M	m d	Elementary/Secondary (0-12)	College (	1-4or 5+)		onmental	•	rol		Medica		egional nter
filed	the int, ii	ပို	17. Father's Name (First, Middle, L	ast)		LUIVIL	Ormerical			First, Middle.			irer
uld be	ie marked other then eumatic event, the M.	To Be	Herbert Lee Co						a Mae			,	
2 should and Men	ie me		19a. Informant's Name/Relationshiphil Core/son	p (Type, Print)			ng Address (Street						
and tealth	om 27 ther tr		20a. Method of Disposition		20h		1 Mt. Her	.mon (	Da			on - City or To	
Pages 1	nt: If ite ry or o		1 X Burial 2 ☐ Cremation  '4 ☐ Donation 5 ☐ Other (Sp		C1-1-	cemetery, cre-	matory or other place ill Memor	y Y	10/24	1		con, MI	
permit. Departm	Importent: if item 27 ie any injury or other trec <u>once</u> .		21 Signature of Funeral Service L			2:	2. Name and Addres	ss of Facili	lity				
	200		23a. Part1. Enter the disease, or o	months the	caused the de	ath Do not on	501 Snow I	Hill	Rd.,	Salisb	ury, M	10 2180	Approximate
			shock, or heart failure. List of	nly one cause on	each line.	0.00	C - W. F.				1651,		Interval Between Onset and Death
	sician edical		disease or condition resulting in death)	a. Chro	(or as a conse	equence of):	we felme	ary	Vise	95e	_		20405
Exa	miner		Sequentially list conditions	b	(**								
p <sub>0</sub>	sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conse	equence of jr							
xecut	and Il-tran	хап	that initiated events resulting in death) Last	c	(or as a conse	equence of):							
9 pg 60	ohysician and the burial-transit	dical E		d									
ificate	g phys as the												
Cent	a attending pt d for use as t	/W	IF FEMALE: 23b. Was decedent pregnant		itcome of pregi		⊒Ectopic pregnancy				23d.	Date of delive	ery
I <b>necolds, r.o. box 60700,</b> The law requires that the death certificate be executed	been signed by the attendir should be detached for use	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nant at time of		Other (specify)					Month	Day Year
that th	ed by		Part II. Other significant condition	18 contributing to a	death but not re	esulting in the u	underlying cause giv	en in Part	ı.	23e. Did to	obacco use d	contribute to the	ne cause of death?
w requires t	n sign	d by	- Adeno Corcini	-		,				1 (2)	res 2□N	o 3 Prot	pably 4 Unknown
5 è	s bee	Completed	Leukojenio							24a. Was			psy findings available
r e	age 2	шо	Anemia							autop perfo	rmed? 2 XNo	prior to co death? 1 ☐ Yes	mpletion of cause of 2₩ No
VICAL Ician: T	tifica tor. p	0	25. Was case referred to medical					26. Plac	ce of Death (	(Check only o		1 1 1 1 1 1 1 1	220,140
ysici	is cer direc	To B	examiner? 1 ☐ Yes 2 <b>X</b> No	Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3 DOA Oth					Other (Specif	iy)
2 £	ter th		27. Manner of Death	28a. Date	of Injury oth, Day Year)	28b. Time o		y at		d. Describe h			
Attending	or: Af	atio	1 Kantural 5 ☐ Pending investig	ation	,,,	(diy		Yes 2	No				
or Att	Jirecto in by t	ertification:	3 Suicide 6 Could n 4 Homicide determine	288. Plac	e of Injury - At ling, etc. (Spec	home, farm, st cify)	reet, factory, office		28	Bf. Location (5 City or Tox		umber or Rura	al Route Number,
pitel	eref [	O	29a. Certifier 1 🔀 Certifying	Physician: To th	a hast of my k	soudadas dos	th see word at the tir	ma data a	and place, an	ad due to the	221122/2\ 221	1	totad
UNISION OF VICAL To the Hospitel or Attending Physician: within 24 hours after death.	To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	edical		xeminer: On the I			th occurred at the tirn exestigation, in my o						
Tot	To T	Σ	29b. Signature and title of certifier				29c. Licens					gned (Month,	
^	Sy		10/5/	1 ms			02	249	86		10/2	-0/06	
19	7		30. Name and address of Reson v	ho completed cau	ise of death (Ite	em 23a) (Type	Print)	01 5	alish	ory k	nd:	21801	
:	Sta Registi		31. Date filed (Month, Day, Year)  OCT 2 3	2006 32.	egistrar's Sig	nature	last .						
	riegisti		00123	2000	MARIE	N. 14	THE CO						

		1 - For State Registrar	State of Ma	aryland		artment of H		nd Mental	Hygiene	2000	35771
Physi	cian	1. Decedent's Name (First, Middle, La	st)	-				2. Date of		y Year	3. Time of Death
	dical	Anna Guidi Casto						acto	-	28 00	0 2225 PM
Exam	niner	4a. Facility Name (If not institution, give				4b. City, Town, or		Death		County of De	
Funan		Washington Count 5. Social Security Number 6.5		(In yrs. la	st birthday)	Hagerst If Under 1 Year	OWII If Under 2	4 Hrs. 8. Date o		ashingt	thplace (State or Foreign
Funer: Directo			I□M 2 <b>X</b> F	75	Yrs.	Months Days	Hours	Min. (Month June	of Birth n, Day, Year, 28, 1	931 Wes	country) st Virginia
1/215-0036 within 72 hours after death with the Maryland ene. then "neturel", or iteme 23s or 28s-f ehow he Medical Exarchment the notified at		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
e Ma	cto	Maryland Washingt	on	Hage	rstow	n					1 ☐ Yes 2 No
ih th	E e	10e. Street and Number				10f. Zip Code				tizen of What C	Country?
• 23e	ā	13927 Kellen Dr.	T 40 W D 1 6		100	21740			U.S		
ter de	i i	11. Marital Status  1 □ Never Married 2 Married	12. Was Decedent E Armed Forces?			Was Decedent of Hi If Yes, specify Cuba	n, Mexican,	Puerto Rican, etc	or No-	14. Race - Am Black, Wh	ite, etc.
036 urs at	þ	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 N If Yes, Give Year or Dates:			1 ☐ Yes 2 No	Specify:			Specify. Whi	lte
21215-0036 od within 72 hours aft giene. or then "neturel", or the Medical Exprire	Completed by Funeral Director	15. Decedent's E (Specify only highest gra	ducation		16a. Dece	dent's Usual Occupa	ation	of working	16b. K	and of Busines	
77 gg gg gg	a dr	Elementary/Secondary (0-12)	College (1-4or 5	+)		kind of work done o DO NOT use retired,	)	or working			
nt. tr	ပိ	12 17. Father's Name (First, Middle, Last	)		Home	maker	10 Mother	's Name (First, Mi		omestic	2
and dibe if intall head of	Be	Antonio Guidi							ooie, maioer rchesi	,	
Maryland of 2 should be file th and Mental Hy 27 is marked oth traumatic event	ဥ	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street a				•	Zin Code)
Ma nd 2 :: alth ar 27 is r trau		Jack Durward Cast		d		Kellen D					
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "neturel; or itsme 23a or 28a-1 ehow eny injury or other traumatic event, the Medical Examinat must be notified at		20a. Method of Disposition	75	20b. Pla	ce of Dispo	sition (Name of matory or other place	e)	Date	20c. L	ocation - City o	r Town, State
Page Page ment: if		1 Burial 2 Cremation 3 4 Donation 5 Other (Speci						1/02/200	6 Hag	erstown	Maryland
Salt semit. Spent	DUC	21. Signature of Funeral Service Lice	nsee		22	2. Name and Addres	s of Facility	Rest Ha	ven Fu	neral (	Chape1
m 4053	a	120 6	1 Lu	\						own Mai	yland 21742
Physicia /Medica		23a. Part1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lin	ie.		istant				Sepho	Approximate Interval Between Onset and Death
Examine			Due to (or as a	a conseque	ence or):	neloce				•	
	je l	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	a conseque		newa	aru	11.7			
Tansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	· Acu	ete	ren	le le	n. lu	1.00			
8760, (Very ate be executed hysicien and the burial-transit		resulting in death) Last	Due to (or as a			0					
(8760, Cate be executed by sicien and the burial-transit	dical	•	d. rne	um.	oni	9					
Box 6 Bath certifi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of the first term of the fi	of pregnance 2 Fetal c	cy death 3	Ectopic pregnancy Other (specify)				23d. Date of de Month	elivery Day Year
P.O. that the d ad by the detached		Part II, Dther significant conditions	contributing to death by	ut not requir	ting in the	nderlying cause gur	en in Part I	230	Did tohacoo	usa contributa	to the cause of death?
ds, F uires tha signed I d be det	d by	Atrial Fibrille		جا ) ت	54	obesit	en in raiti.		1 □ Yes 2	_	Probably 4 Donknown
cord w requir been si	iete	Aurhic Stene		400	Tr :	2.1.1.1		240.1	Was an	24h Mora a	uutanau findinga availabla
Vital Records, sician: The law requires t certificate has been signe irector, page 2 should be v	Completed by		2001	1pe	11 1	ol sere	2 \		autopsy performed?	prior to death?	
ital	0	25. Was case referred to medical	any a	i sec	SK	shape	26. Place	of Death   Check o		1 Ye	s 2 No
vision of Vital Re Attending Physician: The Is closth. ector: Affer this cartificate ha by the tuneral director, page 2	TO B	examiner?  1  Yes 2  No	Hospital: 1 Inpatie	nt 2□E	PVOutpatier	nt 3 DOA Othe	200	sing Home 5 🗆		6 ☐Other (Sp.	ecify)
0 0 - 0		27. Manner of Death 1 Manual 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 2	28b. Time of Injury	t 28c. Injury Work			ribe how inju		
Division of Attending after deeth. Director: After d in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be					Yes 2 □ N				
or At affer of Directin by	i i	4 Homicide determined		ry - At hom :. (Specify)	ne, farm, str	reet, factory, office			on (Street ar r Town, State		Rural Route Number,
Division  To the Hospital or Attending I within 24 hours after deeth.  To the Funeral Director: After completely filled in by the funer		29a, Certifier 1≯Certifying P	hysician: To the best of	of my know	ledne desti	h occurred at the tim	ne date and	I place, and due to	the equation	) and manage	te stated
Hos 24 h Fur e Fur	edical		miner: On the basis of and manner sta	examination	on and/or in	vestigation, in my op	pinion, death	h occurred at the t	me, date an	d place, and du	e to the cause(s)
To the within 2 To the complet	₹ S	29b. Signature and title of certifier				29c. License				ite signed (Mor	
		) myses	111	7		D62	-588	Š	Oct	ober.	247, 2006
5		30. Name and address of person who	completed cause of de	eath (Item 2	23a) (Type,	Print)	Н	a - ca L -	)~ [	^	
		JUDITH MBAO	UTA . 251	E.A	ntre	Print)	1 Floa	gerstou	- n, 1 (		
Regi	State strar	31. Date filed (Month, Day, Year)	32 Registra	ars Signatu	re	and o					

DHMH 17 Rev 1/2001

Registrar

3 2006

			1 - For State Registrar	tate of Maryla		ertment of F ertificate of a			2006	35773
_	Physic /Medi		1. Decedent's Name <i>(First, Middle, Last)</i> Estelle Will	ing D	avis			2. Date of Death Month	Day Year	3. Time of Death
	Examir Funeral Director		4a. Facility Name (If not institution, give street)  4. Facility Name (If not institution, give street)  5. Social Security Number  220-01-9754  6. Sex	Home 7. Age (In yrs	s. last birthday, Yrs.	Houres	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y 11/23/19	4c. County of Death	
	land		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or L	ocation				10d. Inside City Limits
	Mary I-f ehc	ţō	Maryland Cecil		Perry	ville				1 □ Yes 2 □ <b>X</b> o
	od after death with the Marylan or Items 23a or 28a-f ehow miner must be notified at	ai Direc	10e. Street and Number 28 Laurel Road			10f. Zip Code 21903	3	10g	g. Citizen of What Co USA	untry?
900	IL X 12.15-UUSO filed within 72 hours after death with the Maryland Hyglene. ther then "natural", or Items 23a or 28s-f ehow int, the Medical Exeminer must be notified at	To Be Completed by Funeral Director	1 Never Married 2 Married 1	Vas Decedent Ever in Immed Forces?  Yes 2 No No Yes, Give Year or Dates:	U.S. 13.	Was Decedent of H If Yes, specify Cuba  1 ☐ Yes 2 X No	ispanic Origin? (Spe in, Mexican, Puerto f Specify:	cify Yes or No- Rican, etc.)	14. Race - Amel Black, White Specify: W	
Monday of State Office	within 72 h within 72 h sne. Ithen "natu	mpletec	15. Decedent's Educatio (Specify only highest grade cor Elementary/Secondary (0-12)	n mpleted) College (1-4or 5+)	(Give	edent's Usual Decupi e kind of work done of DO NOT use retired nemaker	ation during most of workin )	ng	b. Kind of Business/I	ndustry
7 2 2	a la b s	o Be Co	17. Father's Name (First, Middle, Last) Benjamin F. Willing		1101	HEMONEL	18. Mother's Name Annie E	(First, Middle, Ma		
			19a. Informant's Name/Relationship (Type, H Glenn Davis/son	Print)			and Number or Rura		City or Town, State, Z 21903	ip Code)
<u> </u>	Dallinore, M permit. Pages 1 and 2 Department of Heelth Importent: If Item 27 i any Injury or other tra		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from State	Place of Dispondering Place of Dispondering	osition (Name of imatory or other place) ill Memory	<sup>e)</sup> 10/28		c. Location - City or 3 Hebron, MI	
9	permit. Depart Import any Inj		21. Signature of Funeral Service License	rey CFS	0 3	ioiiowaym ool Snow H	Tuneral Ho Hill Rd.,			ssociation 04
•	Pnysician /Medical		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death)	Wellemit		iter the mode of dyin	g, such as cardiac o	respiratory arrest		Approximate Interval Between Onset and Death
09283	filcate be executed trace and as the burial-transit	edical Examiner	Sequentially list conditions, 1 stry, leading to strand a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	White to	quence of): quence of): quence of):	nisense ense				
2	the death cert by the attendin	Physician/Me	in the past 12 months?	yes, outcome of pregr □Live birth 2 □ Fet □ Pregnant at time of □ Unknown	aldeath 3[	□Ectopic pregnancy □ Other (specify)			23d. Date of delik Month	very Day Year
	law requires that les been signed to 2 should be detailed.	Š	Part II. Other significant conditions contribu	ting to death but not re	sulting in the u	inderlying cause give	en in Part I.		cco use contribute to 2 □ No 3 □ Pro	/
telle W	The law received hes because page 2 sho	Completed			<del></del>	<u></u>		24a. Was an autopsy performe	grior to co	opsy findings available ompletion of cause of
3te/le	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lal:		Othe	26. Place Death			
111	g Phys er this eral dii	n; To	27. Mann of Death 28	a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o	nt 3 DOA	4 Priursing Hom	ne 5 Residence  8d. Describe how	e 6 Other (Speci	fy)
2	Attending I death. ctor: After y the funer	atlo	2 Accident investigation	(Month, Day Year)	Injury		? /es 2 □ No			
N. 19, E	or Attender death of Director:	Certification;	3 Suicide 6 Could not be determined 28	le. Place of Injury - At t building, etc. (Spec	nome, farm, str ify)	reet, factory, office	2	8f. Location (Stree City or Town, S	et and Number or Rui State)	al Route Number,
Ö	To the Hospital or Attending Physician: The Within 24 Hours after death.  To the Funeral Director: After this certificete he completely filled in by the funeral director, page	Medical C	29a. Certifier   1 Certifying Physicial   2 Medical Examiner:	n: To the best of my kn On the basis of examin and manner stated.	owledge, deat ation and/or in	th occurred at the time to the time of the	e, date and place, a pinion, death occurre	nd due to the caus d at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
	To t with To I	2	29b. Signature and title of certifier  HI 4W 9im M	Ŋ.		29c. License	number HV	29d.	Date signed (Month)	Day, Year)
ı	100	ta	30. Name and address of person who comple	ted cause of death (Ite	WI	1 4	mn 2/09	78	1	
	Sta Registr		OCT 2 6 2006	1 /200	H A					

ORIGINAL

			1 - For State Registrar		of Maryla		artment of rtificate o			F	leg. No.	006	35774
	Physici	an	Decedent's Name (First, Middle	e, Last)						<ol><li>Date of Dea Month</li></ol>	ith Day	Year	3. Time of Death
	/Medic		Sandra	Le		Davis				October 2			2:30 A M
9	Examin	ier	4a. Facility Name (If not institution		umber)		4b. City, Town		of Death		-	ounty of Deat	
		2	6914 Elkins Aven		7 800 (10	n last highest	Oxon If Under 1 Yea		24 Hrs. I	0.00		nce Geo	
	Funeral		5. Social Security Number 187–32–3948	6. Sex 1 ☐ M 2 ☑ F	63	s. last birthday) Yrs.	Months Day		Min.	8. Date of Birth (Month, Day 12/12/1	Year)	9. Birt	hplace (State or Foreign untry)
	Director		Usual Residence of Decedent	A	0.5					12/12/1	942	Peni	nsylvania
	/land		10a. State 10b. County			City, Town or Lo	cation						10d. Inside City Limits
:	Man Hash	to	Maryland Prince	George	Ox	on Hill							1 ☐ Yes 2X No
	r 28	lrec	10e. Street and Number				10f. Zip Code		-		10g. Citizer	of What Co	untry?
	23a C	Funeral Director	6914 Elkins Av	enue				20745			US	SA	
	dea dea	ner	11. Marital Status	12. Was De Armed F	cedent Ever in	U.S. 13.	Was Decedent o	f Hispanic Ori	gin? (Spe	cify Yes or No-	14.	Race - Ame Black, White	
9	or it	y FL	1 Never Married 2 XMar	ned 1 🗆 Yes If Yes, G	2 <b>X</b> No ive		1 ☐ Yes 2 🛣 N			, , , ,		ecify:Whi	
21215-0036	within /2 nours atter death with the Maryland ene. Then "netures" or items 23e or 28e-f show the Modical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced		Dates:	11. 5				1			
<u>1</u>	"nat	Completed	(Specify only highe	it's Education st grade completed	)	16a. Dece (Give	dent's Usual Occ kind of work dor DO NOT use reti	upation ne during mosi red)	t of workii	ng	16b. Kind	of Business/	Industry
12	than than	mc	Elementary/Secondary (0-12)	2 College	(1-4or 5+)	Assis	tant Br	anch Ma	anage	er	Banki	ing	
0	Hyg other ent,		17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name	(First, Middle,	Maiden Su	mame)	
lan	id be ental ked (	To Be	James E. Meredi	th				Esth	ner	H. Red	lman		
Maryland	Shou and M amar umat	-	19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address (Stre	et and Numbe	er or Rura			own, State, Z	Tip Code)
Σ	alth a alth a 27 is		William R. Davi	sIII/Husl	oand	6914	Elkins	Avenue	0xon	Hi11.	M1. 2	20745	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene and the remains and injury or other traumatic event, the Macdical Examinar must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation	2 X D	20b	Place of Dispo	sition (Name of matory or other p	lace)		ate		ion - City or	Town, State
<u>.</u>	Page ment ant: if		4 Donation 5 Other (S				Memoria		. 10/	26/06	Lower	Burre	e11,PA.
att	permit. Departr Imports any int		21. Signat of Funeral Service	Licensee		22	. Name and Add	lress of Facilit	y Geor	ge P. Kal	.as Fun	eral Ho	me P.A.
Ω	8 2 5 5		SNO. Kan	10 10			6160 Oxon	Hill Ro	oad Ox	on Hill,	Maryla	<b>nd</b> 20	745
4.			23a. Part1. Enter the disease, or shock, or heart failure. List	compligations that only one cause on	caused the de	ath. Do not ent	er the mode of d	ying, such as	cardiac o	r respiratory arr	rest,		Approximate Interval Between
F	hysician		Immediate Cause (Final disease or condition	. 3	REA			CER					Onset and Death
	/Medical		resulting in death)	Due to	(or as a cons								, ,
	Examiner		Sequentially list conditions,	b						-			
	sit eq	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a sons	aquende of):							
	ecut and I-tran	хал	that initiated events resulting in death) Last	c.	(or as a cons	anuance of):						-	
8760,	De ey icien Duria	calE			(01 43 4 30113	aquanios or).							
687	death certificate be executed e attending physicien and id for use as the burial-transit	9		d							-		
×	Certifi ding	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or	utcome of preg	nancy					234	. Date of deli	NADY.
Вох	atter for u	clar	in the past 12 months?		birth 2 ☐ Fe nant at time of		Ectopic pregnar Other (specify)	псу			200	Month	Day Year
		lys	1 □ Yes 2 <b>](</b> □ No 9 □ Unknown	9⊡ Unki			(						
	law requires that the as been signed by th 2 should be detache	by Pi	Part II. Other significant condition	ons contributing to	death but not r	esulting in the u	nderlying cause	given in Part I.		23e. Did to	bacco use	contribute to	the cause of death?
rds	w requires been sig									1 🗆 Y	es 2 🗆 N	lo 3∏Pro	bably 4 Unknown
Division of Vital Records,	s bee	Completed								24a. Was a	ın 2	4b. Were au	topsy findings available
26	Ine lav	E O								autops	med/?	death?	ompletion of cause of
ta		a l	25. Was case referred to medica					26 Place	of Death	Check only or	2₩ No	1 🗆 Yes	2 No
>	ysica s cer direct	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	☐ ER/Outpatier	t 3 DOA	\who =		ne 5 🌁 Resid		Other (Spec	u(v)
0	Attending Prysician: r death. sctor: After this certific by the funeral director.		27. Manner of Death	28a. Date		28b. Time o				8d. Describe h			,,,
Ö	ath. rr: Att	atio	1XXNatural 5 ☐ Pendir 2 ☐ Accident investi	9	nin, Day 1 ear)	Hijury		Yes 2 1	No				
<u>vis</u>	ar de recto by th	ti 1	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 286. Plac	e of Injury - At ding, etc. (Spe-	home, farm, str	eet, factory, offic	е	2	8f. Location (S. City or Town		umber or Ru	ral Route Number,
۵	rs afte	Certification;		- Julia	ang, etc. (ope	ony,				Only or 10th	ii, Siale)		
	to the Hospital of Attanding Phy- within 24 hours after death. To the Funeral Director, After this completely filled in by the funeral di	edical	29a Certifier 1.2 Certifyin (Check only 2. Medical	ng Physician: To the Examiner: On the	a bast of my le	nowledge, deat	onnumed at the	time date an	d clace, a	nd due to the e	ausu(s) and	d marrier as	tialsd.
	the F the F the F	Medi	one)	and ma	nner stated.								
.00	within To the comple	Σ	29b. Signature and title of certifie	2-1		1	1	nse number					Day, Year)
(1			Ucas	my		T	BA	652	143	0 6	/6/	23	, circles
1	0)		30. Name and address of person	who completed cau	ise of death (It	em 23a Type,	Print) Iv	an Akyen	tijev.	ich MD V	10 -	クァス	
1			31. Date filed (Month, Day, Year)	umore	HIVE-	nature	018,	14161	coni	ua l	4. 2	-250	7
1	Sta Registr		OCT 242	006 Se	an B	Ste / nature  Spen	de						

,	*		State of	Maryland	/ Department of	Health and M	lental Hygi	ene no c	00775
			1 - State Registrar		Certificate of	Death		g. No. UUD	33113
	Physici /Medio		<b>_</b>		Dequir	ll-	2. Date of Death	20 06	3. Time of Death
	Examir	er	4a. Facility Name (If not institution, give street and num  ANN ANI Will Medic  Medic  O	of C	+Z ANNO	or Location of Death		4c. County of Dea	ıın
	Funeral Director		5. Social Security Number 577-36-2534 6. Sex 1 ☐ M 2점 F	7. Age (In yrs. Ia.	Yrs. If Under 1 Year Months Days	Hours Min	8. Date of Birth (Month, Day, Oct. 14,	9. Bi 1929 Was	hhplace (State or Foreign ountry) shington, DC
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City,	, Town or Location				10d. Inside City Limits
	a-f sho	ctor	Maryland Anne Arundel		Edgewater				1 ☐ Yes 2 ☒ No
	vith the	Funeral Director	10e. Street and Number		10f. Zip Code	•	10	g. Citizen of What C	ountry?
	ns 23s	erai	1811 Loreley Road  11. Marital Status 12. Was Dece	dent Ever in U.S	21037 3. 13. Was Decedent of	Hispanic Origin? (Spe	ecify Yes or No-	USA 14. Race - Am	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other then "natural", or items 23e or 28e-1 show say injury or other traumatic event, the Medical Exam nat must be notified at once.	by	Armed For 1 Never Married 2 Namaried 1 Yes 1 Yes 3 Widowed 4 Divorced Year or Da	ces? 2 <b>X</b> No	If Yes, specify Cut  1 ☐ Yes 2 ☑ No	ban, Mexican, Puerto	Rican, etc.)	Black, Wh.	
21215-0036	72 ho "natur	Completed	15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of works	ing 1	6b. Kind of Business	/Industry
121	within iene. r then "	ошо	Elementary/Secondary (0-12) College (1-12)	4or 5+)	Administrati	_	ant	Telepho	one Company
	be filed tal Hygi d other	BeC	17. Father's Name (First, Middle, Last)	'		18. Mother's Name			
Maryland	ould b	Tof	John Anselmo		10- 14-11 14-11 (Charles		ret Cosi		Zio Codol
Ma	id 2 sh ith and 27 Is m 27 Is m		19a. Informant's Name/Relationship (Type, Print)  Mary DeGuire Romagnoli/ I	)aught ar	19b. Mailing Address (Stree				
Je,	of Heal		20a. Method of Disposition	20b. Pla	ace of Disposition (Name of metery, crematory or other pla		Date 2	Oc. Location - City of	
altimore,	Pages ment of ant: If It		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)	Metro	opolitan Cremator	Y 200	per 24,	lexandria,	Virginia
Bail	Depart Depart Import eny in		21. Signature of Funeral Service Licensee	en .		sity Blvd	, W, Silv	ver Spring	, MD 20901
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	/Medical Examiner			or as a conseque	1 2	MIDERT	en sici	L	10 4802e
· *		Jer	Sequentially list conditions b.	or as a conseque	J	, (	7		Jean 23
	be executed Icien and burial-translf	Examiner	that initiated events c.	what	_	ferry 1	UI sea	81-	10 gears
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99	tificate ig phys as the		0.	0	J				0
.O. Box	The law requires that the death certificate be executed the has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?	ome of pregnand th 2 ☐ Fetal of ant at time of dea wn	death 3 Ectopic pregnand	су		23d. Date of de Month	livery Day Year
<u>α</u>	w requires thet been signed by should be deta	ed by Ph	Part II. Other significant conditions contributing to de	ath but not result		iven in Part I.	23e. Did toba		o the cause of death?
Vital Records,		Completed by	,				24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital:			26. Place of Death			
ō	g Phys er this eral dii	n: To	27. Manner of Death 28a. Date o	f Injury 2	28b. Time of 28c. Inju	4   Nuising no	me 5∐ Resider 28d. Describe hov	ice 6 Other (Spe vinjury occurred	ecify)
sion	Attending For death.  Ctor: After by the funerations	atio	2 Accident investigation	n, Day Year)		Yes 2 No			
Division	l or Attendated after death Director:	Certification:	3 Suicide 6 Could not be determined 28e. Place buildin	of Injury - At hom g, etc. (Specify)	ne, farm, street, factory, office )	•	28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
	To the Hospital or Attending Physicien:  within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical Ce	29a. Certifier 1 Certifying Physician: To the (Check only one) 1 Medical Examiner: On the ba	sis of examination	vledge, death occurred at the toon and/or investigation, in my	time, date and place, opinion, death occurr	and due to the cau ed at the time, dat	use(s) and manner a te and place, and du	s stated. e to the cause(s)
)	Within Comple	Me	29b. Signature and title of certifier AKhor	ed. 1	A ( 9 )	005394		d. Date signed (Mon	th, Day, Year)
	•		30. Name and address of person with completed gauss	20	25 Kidgely	. Avenue	Anr.	iguls,	422 d 140/
	Sta Registi		31. Date filed (Month, Day, Year) OCT 2 3 2006	egistrar's Signatu	Specie			V	

		For State Registrar	State of Mar	yland / [	Departm Certific	ent of He <i>ate of E</i>	ealth and M Death		ene2 ()	06	35776
Physicis		1. Decedent's Name (First, Middle, Las					-	2. Date of Death Month		Year	3. Time of Death
Physicia /Medic		PATRICIA		DE	ELU			10 2		2006	1332PM
Examin	er	4a. Facility Name (If not institution, give		T 1100			Location of Death		4c. County		
		WASHING-TON / 5. Social Security Number 6. S		In yrs. last birt		der 1 Year	If Under 24 Hrs.	8. Date of Birth	mo		someny.
Funeral Director		577-54-6412	☐ M 203cF		Yrs. Mont		Hours Min.	(Month, Day, Feb. 25,	Year) 1941	Coun	lace (State or Foreign htry) Land
ryland how		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Town	or Location		· · · · · · · · · · · · · · · · · · ·			10	Od. Inside City Limits
Ba-f-	Director	Maryland Montgo	mery	S	ilver	Spring	<u> </u>				1 ☐ Yes 2 🛣 No
3a or 2		10e. Street and Number 10515 Sweetbriar	Parkway		10f.	Zip Code 20	903	10	g. Citizen of V U	What Coun	try?
ING 21215-0036  be filed within 72 hours after death with the Maryland ital Hygiene. Ital Hygiene. Ind other then "natural", or items 23e or 28e-f ehow event. If a Medical Exertiner must be rigified at	y Funeral	11. Marital Status 1 □ Never Married 2 Married	12. Was Decedent Ev. Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give	er in U.S.		ecedent of His specify Cuban s 28 No	spanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ce - America ck, White, e	
5-0036 72 hours at natural; or alcal Exemples	ted by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:	16a.	Decedent's U	Isual Occupat	tion	11	6b. Kind of Bu		
1215- within 72 ene. then 'nat	Completed	(Specify onfy highest gra	de completed)  College (1-4or 5+)		(Give kind of life. DO NO ealtor		uring most of worki	ing			
d 2 filled v hygie		17. Father's Name (First, Middle, Last)		K	earcor		18. Mother's Name	e (First, Middle, M	Real I		е
Maryland d 2 should be file th and Mental Hy I? Is marked oth treumatic event	To Be	Charles Edmund	O'Brien, Sr	•				e Cecelia		,	
C = W F		19a. Informant's Name/Relationship (1) Frank C. DeLuca,		19b. 10	Mailing Addr 515 Sw	ess <i>(Street ar</i> eetbri	nd Numberor Rum ar Parkwa	ay, Silve	City or Town, er Spr:	State, Zip ing,	Code) MD 20903
Fages 1 and Peatle of Healt int: If Item 2 any or other		20a. Method of Disposition  12 Burial 2 Cremation 3 □ 4 □ Donation 5 □ Other (Specify		20b. Place of cemeter,	v, crematory o	or other place,	Octo	ber 25	Oc. Location -		
Baltim permit. Pag Depertment Important: I any injury o		21. Signature of Funeral Service Licen			Franc	and Address	of Facility Collins 1	Funeral F	Home Tr	nc.	g, Maryland
48360	-	232 Part From the disease or come	Cooley	a danth. Da a						ring,	MD 20901
		23a. Part1. Enter the disease, or comp shock, or neert failure. List only Immediate Cause (Final									Approximate Interval Between Onset and Death
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pe sit	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence o	f):						
60, be executed sicien and burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as a c	OBSERVINGS O	f).					_	
<b>58 / 60,</b> ficate be en physicien is the buria	edical E	i i	d	onsequence o	1).						
68/ tifficate ng phys as the	ledi		<b>v</b> .								
HECOTGS, P.O. BOX 68/6U, The law requires that the death certificate be executed the has been signed by the attending physicien and age 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 [ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death	3 Dectopio	pregnancy (specify)			23d. Date Mor	e of deliver	ry Day Year
FS, F.	by Ph	Part II. Other significant conditions co	ontributing to death but r	not resulting in	the underlyin	g cause given	in Part I.	23e. Did toba	cco use contr	ibute to the	e cause of death?
w requires to been signer should by								1 ☐ Yes	2 🗆 No	3 🗌 Proba	ably 4 Donknown
VITAI HECOTO licien: The law requir certificate has been si rector, page 2 should I	Completed						-	24a. Was an autopsy perform	24b. V	leath?	osy findings available apletion of cause of
VITAL F	Bec	25. Was case referred to medical examiner?					26. Place of Death		1	☐ Yes 2	2× No
OT V Physic	2	1 Pyes 2 No	Hospital: 1   Inpatient	2 Ser/Out	patient 3	Other		ne 5□Residen	ce 6 □Othe	er (Specify)	)
ing P	<u>:</u>	27. Manner of Death 1   Natural 5 □ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Ti	jury	28c. Injury a Work?		28d. Describe how	injury occurre	ed	
INISION I or Attending after death. Director: Afte	ertification	2 Accident investigation 3 Suicide 6 Could not be	29a Plane of Injury	A4 h = = = 6==	M		es 2 No	20( 1 (0)			
S after I Direction by	Cert	4 ☐ Homicide determined	28e. Place of Injury building, etc. (	Specify)	n, street, ract	огу, опісе		28f. Location (Stre City or Town,	et and Numbe State)	or Hurai	Houte Number,
	edicai	29a. Certifier (Crock only one)  1 Certifying Phy 2 Medical Exam	rsician: To the best of n iner: On the basis of ex and manner stated	amination and	death occurre or investigati	ed at the time on, in my opir	, date and place, a nion, death occurre	and due to the cau ed at the time, date	se(s) and mar and place, a	nner as sta and due to	ited. the cause(s)
To the Within To the		29b. Signature and title of certifier	7		2	29c. License r	number	290	. Date signed	(Month, D	Day, Year)
		V(NUL	TND			6	0319		10 2	/ 1	2006
D		30. Name an indress of person who d		h (Item 23a) (1	ype, Print)	· ·	- / · /		-/	1	2006.
		DARCIE	MHA	MM	en	7600 C	Carroll A	venue, T	akoma	Park,	MD 20912
Stat Registra		31. Date filed (Month, Day, Year) OCT 2 3 20	32 Registrar's	Signature	berte	7					

To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi  $\mathcal{O}_{\prime}$ 

or Attending Physicien: The law requires that the death certificate be executed

Box 68760

Division of Vital Records, P.O.

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Pages 1 and 2 should be f nent of Health and Mental P ant: If item 27 te marked of

30. Name and address of person the completed cause of death (Item 23a) (Type, Print)

D0064560

OCTOBER 21, 2006

State of Maryland / Department of Health and Mental Hygiene 006 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:49 October 16, 2006 Willie **Edwards** Mae /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🛣 F 68 Yrs. Director 248-64-6952 08/24/1938 South Carolina Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "naturel", or iteme 23s or 28s-f show the Modical Examinar trust be notified at 1KYes 2 No Director MD Prince Georges Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20748 United States 4316 23rd Place Funeral filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☑ No Specify: Completed by 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 Licensed Practical Nurse Healthcare permit. Pages 1 and 2 should be filed v Department of Heelth and Mantal Hygies Important: if Item 27 is marked other th eny injury or other treumatic event, that once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willie Mae Rillie Geiger Eugene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David E. Geiger/Brother 2521 Southern Ave. #201 Temple Hills, MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/23/06 Suitland, MD Lincoln Mem. Cem. 22. Name and Address of Facility Montgomery-Cheatham Funeral Service 21. Signature of Fuñeral Service Ligensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. P.O. Box 388 Upper Marlboro, MD 20773 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiopulmonary Failure /Medical Due to (or as a consequence of) Examiner Metastatic Ovarian Cancer Sequentially list conditions. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on Examiner or Attending Physician: The law requires that the death certificate be executed buriel-transit Bowel Obstruction and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Certification; To Be Completed by Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 🛣 No 2 Fetal death 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other. 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 ANatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 X Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner at etated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier M.D. D0064100 October 17, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smitha Bhikkaji 1500 Forest Glen Road Silver Spring, MD 20910-1484 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

		1 - For State Registrar	State	of Marylar		artment of F tificate of		iu Mentan	Reg. No	1116	35779
eş C	45	Decedent's Name (First, Middle,	Last)					2. Date of Month	-		3. Time of Death
Physi /Med		Dale Beatrice	Forinash					Octobe	r 23	2006	12:02A M
Exam		4a. Facility Name (If not institution,	•		0.6	4b. City, Town, o	_		1	County of Death	h
		Calvert Manor   5. Social Security Number	neacinca 6. Sex	7. Age (In yrs.		Risin If Under 1 Year	0	Hrs. 8. Date of	Birth	9. Bint	hplace (State or Foreign
Funera Directo		219-30-0331	1 □ M 2 <b>X</b> F		5 Yrs.	Months Days	Hours	Min / (Month.	Dav. Year	l Coi	st Virginia
pu 💌		Usuel Residence of Decedent  10a, State 10b, County		10c Ci	ity, Town or Lo	cation					10d. Inside City Limits
Aaryla f aho	ŏ	Maryland Ceci	Q		onowing						1 ☐ Yes 2 <b>∑</b> No
r 28a-	Director	10e. Street and Number	C		onowing	10f. Zip Code			10g. Ci	tizen of What Co	untry?
death with the Maryland me 23s or 28s-f show		25 Grace Ann	Drive			219	18		Uni	ted Sta	tes
er dea	Funerai	11. Marital Status	Armed F		J.S. 13. \	Was Decedent of F f Yes, specify Cub	lispanic Origin an, Mexican, I	n? (Specify Yes or Puerto Rican, etc.)	No-	<ol> <li>Race - Amer</li> <li>Black, White</li> </ol>	
OUSO hours after turel, or its	by F	1 ☐ Never Married 2 M Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 Yes If Yes, G Year or			1 □ Yes 2X No	Specify:			Specify: Wh	ite
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within 72 ene. then "nat	mple	Elementary/Secondary (0-12)	1	(1-4or 5+)	life. l	OO NOT use retire	d)	a nonning	D., 4	of Cal	~ ~ <i>R</i> .
0 5 5		17. Father's Name (First, Middle, L	ast)		vay	Matron	18. Mother's	s Name (First, Mid		olic Sch	0015
land Id be filk ental Hy ked oth Ic event	To Be	Edgar Mills	•					a Shreve		,	
Mary d 2 shou th and M 7 is mar traumat	-	19a. Informant's Name/Relationshi	ip (Type, Print)		19b. Mailir	ng Address (Street	and Number	or Rural Route Nui	nber, City	or Town, State, Z	lip Code)
re, M s 1 and 2 f Health Item 27 other tru		Bonita Adkins/De	aughter	205		Pilot To	wn Road	d. Conowa			
0 0		20a. Method of Disposition 1   Burial 2 □ Cremation		n State Elk	cemetery great	natory or other pla	ce)			ocation - City or	
		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service L.			Garden	S	10	-30-2006 R.T. Foa			Virginia
Departition of the point of the	Suce	Kichard &	2 Go	o die							land 21911
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		23a. Part1 Enter the disease, or of shock or heart failure. List o	complications that only one cause on	t caused the dea each line.	th. Do not ent	er the mode of dyii	ng, such as ca	ardiac or respirator	y arrest,		Approximate Interval Between
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	Physici	an	Decedent's Name (First, Middle, La			EEDD)	7T T		2. Date of Deat Month	Day	Year	3. Time of Death
	/Medic	al	TAMMY	MARIE		FERR			October			12:27 P M
	Examin	er .	4a. Facility Name (If not institution, give		. 1		· ·	or Location of Death			y of Death ceste1	_
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*	Funeral Director			1□M 2\\ F	45	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, FEB. 15	Year) 1961	Mary	place (State or Foreign htry) 1 and
w .			Usual Residence of Decedent		7.7				TED. IJ	, 1701	mary	Tana
5 2	yland		10a. State 10b. County			, Town or Lo					1	0d. Inside City Limits
13 2	e-f s	ctor	Maryland Worce	ster	(	Ocean	City					1 X Yes 2 No
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3	23e	ia	3,66 Street,				21842			United	l Sta	ates
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3 8	within 72 hours after death with the Maryland ene. then "natural", or Itams 23e or 28e-f show the Madical Examiliter mast be motified at	pa pa	15. Decedent's E	Year or Dates:		16a Dece	tent's Usual Occur	nation		16b. Kind of E	lusingse/In	dustry
5.	In 72 Ina	olet	(Specify only highest gr	ade completed)		(Give	kind of work done DO NOT use retire	pation during most of work id)	ing	100. 14110 01 2	,43111033/111	dustry
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36/3006 337 Vland 21215-00	filed Hygid other	Be Completed	17. Father's Name (First, Middle, Last	)	· · · · · · · · · · · · · · · · · · ·			18. Mother's Nam	e (First, Middle, I	Maiden Sumai	ne)	
100 CC	Merital Merital arked o	ToB	Thomas L	. Allen,	Sr			Alla	Trua	Κ		
10/ <i>3し/300に</i> 13 <i>37</i> Maryland 21215-0036	충분		19a. Informant's Name/Relationship	Type, Print)		19b. Mailir	ng Address (Street	and Number or Rur	al Route Number	City or Town	, State, Zip	Code)
2 E	alth a 127 is	0	Anna Allen / M	other		570	8 Vassar	Dr. / Col	llege Pa	ck, MD	20	740
	es 1 a of He fitem		20a. Method of Disposition	Domesial from Chate	Ce	emetery, crei	sition (Name of natory or other place	ce)		20c. Location		
	it. Page rtment o rtant: If injury or	<sup>1</sup>	1 ☐ Burial 2 【XCremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Speci	fy)	Fre	deric	c Cremato	ory Oct.	31,2006	Freder	ick,	Maryland
01	mit. ports ports y inju	0	21. Signature of Funeral Service Lice	nsee //		22	. Name and Addre	ess of Facility Sta	auffer F	ıneral	Home	
<u> </u>	Dep Imp any		xaymond	15 ell	KI	n)	1621 Opos	ssumtown I	Pike/ Fr	ederick		21702
			23a. Part 1. Enter the disease, or comshock, of heart failure. List only	plications that caused one cause on each lin	the death	. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arre	est,		Approximate Interval Between
	Physician		Immediate Dause (Final disease or condition		,	Sho						Onset and Death
	/Medical		resulting in death)	Due to (or as								
9	Examiner		So appricable flet or p. 91 and	p. Pelvi	C 1	Fn fla	mater	n Disea	se			3 DAYS
	D =	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	uence of):						
0)	acute ind trans	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c								
84 - (58). 760,	ite be executed lysician and ne burial-transit	ũ	1830tting in deathy Last	Due to (or as	a consequ	ience or):						
-S-	2 2 2	dical		d								
の を を を を を を を を を を を を を を を を を を を	aw requires that the death certificat as been signed by the attending phy 2 should be detached for use as th	Completed by Physician/Med	IF FEMALE:	23c. If yes, outcome	of precipa	DC1/						
अाप Box	ath catternation	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal	death 3	Ectopic pregnancy Other (specify)	у			ite of delive onth	Day Year
<u>.</u>	the de	ysic	1 ☐ Yes 2 ☑No 9 ☐ Unknown	9 Unknown	tillie of de	adii 5						
P.O.	that the death ed by the atte detached for	h h	Part II. Other significant conditions	contributing to death be	ut not resu	ılting in the u	nderlying cause giv	ven in Part I.	23e. Did tob	acco use con	tribute to th	ne cause of death?
98°	uires tha signed d be de	d b	Ethanol abus-	_					1 🗹 Ye	s 2 No	3 Prob	ably 4 Unknown
720	v requir been s should	ete							24a. Was a	245	Ware auto	psy findings available
3—6	The lay	mp	- WILDOTALDON						autops	v i	prior to condeath?	mpletion of cause of
E 7. E			Ascites	[					1 Yes 2	No	1 🗆 Yes	22No
57.5	ding Physicien:  After this certific funeral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	-1 001	ER/Outpatier	oth	26. Place of Deat	h (Check only on			
1000	iling Phya J. After this funeral di	<b>}-</b>	27. Manner of Death	28a. Date of Injui (Month, Day		28b. Time of			28d. Describe ho			V)
- on	ding th. Afte fune	tior	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Year)	Injury	Wor					
Delli Dolosion	Attending Physicien: r death. ector: After this certific by the funeral director,	fica	3 Suicide 6 Could not b	28e. Place of Inju	iry - At ho	me, farm, str	eet, factory, office				per or Rura	l Route Number,
<b>ER a</b>	after Dire	Certification:	4  Homicide	building, etc	c. (Specify	")			City or Town	, State)		
5,	To the Hospitel or Attent within 24 hours after death To the Funeral Director; completely filled in by the			hysician: To the best								
	ne Ho ne Fu bletel	edical	(Check only 2 Medical Exa	miner: On the basis of and manner sta	examinat ited.	ion and/or in	restigation, in my o	opinion, death occur	red at the time, da	ite and place,	and due to	the cause(s)
	To 11 within To 11 comp	Σ	29b. Signature and title of certifier				29c. Licens	se number	25	d. Date signe	d (Month,	Day, Year)
			Tulln	0			400	63448	00	Tac	200	6
	7		30. Name and address of person who				Print)					
_	•			tei no	791	SUAN	steet	BENLIN	mo	2-1211		
	Sta		31. Date filed (Month, Day, Year)  OCT 3 0	2006 32. egistra	ar's Signal	de 1	medi					
	Registr	ar	00190	Janes.		- 17						

_			For State Registrar		State of	Marylan		artmen rtificate			and M		eg. No.	HILL	357	
	Physici	an	Decedent's Name (F.		_	-						2 Date of Dea Month	Day	Yeer	3. Time of [	
	/Medic	al	Brenda  4a. Facility Name (If not	Pear			abian	45 Ch. 3	Tour of	Location of	of Dooth	Octobe		2006 ounty of Death	8:55	p <sup>M</sup>
	Examin	er	317 Linde	_		")			dgew		) Deali			nne Ar	unde1	
-	Funeral		5. Social Security Numb	ber 6. Se	9x 7.	Age (In yrs.	last birthday)	If Under	1 Year	If Under	24 Hrs. Min.	8. Date of Birth			place (State or	Foreign
	Director		220-58-182	2.5	⊒м 2 <b>ХДХ</b>	80	Yrs.	Months	Days	Hours	MIN.	8. Date of Birth (Month, Day Dec. 8	1925	Eng	land	
	and *		Usual Residence of De-	cedent b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City	Limits
	Manyl f eho	ō	MD A	Anne Aru	nde1		Edgewa	ater							1 🗆 Yes	2∏No
	r 28a	Director	10e. Street and Number				8	10f. Zip	Code			1	0g. Citizer	of What Cou		
	th wit	at D	317 Linden	a Avenue					210	37				USA		
	tems fr	Funeral	11. Marital Status		12. Was Decede Armed Force	<u>s?</u>	.S. 13.	Was Deced If Yes, spec	ent of History Cubar	spanic Ori n, Mexican	gin? (Sp i, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,		
36	rs afte	by F	1 ☐ Never Married 3 XWidowed 4 ☐		1 ☐ Yes 2 [ If Yes, Give Year or Date			1 ☐ Yes 2	2X No	Specify:			Sp	pecify:	White	
21215-0036	within 72 hours after death with the Maryland ene. then *natural', or items 23e or 28e-f ehow he Madical Examiner must be natified at	ted	15.	. Decedent's Ed	ucation		16a. Dece	dent's Usua	I Occupa	ition	6 1		16b. Kind	of Business/In	dustry	
215	thin 7.	Completed	(Specify of Elementary/Seconda	only highest grad ry (0-12)	College (1-4d	or 5+)	life.	kind of wor DO NOT us	e retired)	uring mosi	t of work	ing				
21	e filed wi al Hygien other th vent, the	Con	12				Home	emaker	c	40.14.45		(F) . A		Home		
Maryland	0 = O =	Be	17. Father's Name (Firs									e (First, Middle, a B. Li				
Ž	should be and Mental marked umatic ev	ဥ	19a. Informant's Name		ype, Print)		19b. Mailie	ng Address	(Street a			al Route Number			Code)	
	and 2 s lealth ar m 27 is her treu		Victoria F	abian (	Daughter	)	317 1	Linder	a Ave	enue,	Edg	ewater,	MD 2	1037		
ore,			20a. Method of Disposit		Bomoval from Sta	1 /	Place of Dispo cemetery, crei	sition (Nam	ne of ther place	9)	I	Date	20c. Locat	tion - City or To	own, State	
Ĕ	Pag ment ant: }		4 ☐ Donation 5 ☐	Other (Specify	)		tro Cre	emator	сy	1	0-25	-2006	Balti	more, 1	4D	
Baltimore,	permit. Pages Depertment of th Important: If Its any Injury or of		21. Signature of Funera	al Service Ocens	500		22	. Name and Harde	esty	Fune	ra1	Home, P	.A.			
	402 6 4		23a Part1 Foter the d	lisease or comp	lications that caus	ed the deat	h. Do not ent	905 (	Gales	svill	<u>e Ro</u>	ad, Gal	esvil	le, MD	20765 Approximate	
			23a. Part1. Enter the d shock, or heart fa Immediate Cause (Fina			line.		(	fa	refi	~~	or respiratory an			Interval Betw Onset and De	
	Pnysician /Medical		disease or condition resulting in death)	-	a	as a conseq			- / -	-						
r	Examiner		Coquentially list conditi	ions	b											
	ν <del>π</del>	iner	Sequentially list condition any, leading to initial cause. Enter Underlyin	diata		as a consec	uanoa of):									
	be executed iclen and burial-transit	Examiner	Cause (Disease or injust that initiated events resulting in death) Last		c	as a conseq	uence of):									_
760,	ate be executed nysicien and he burial-transit	cai E			a											
687		ed			d											
Вох	death certifica e attending ph id for use as th	Physician/M	IF FEMALE: 23b. Was decedent pre	agnam	23c. If yes, outcom			Ectopic pre	annancv				23d	. Date of delive		
B	e deal	sicie	in the past 12 mor 1 ☐ Yes 2 No		4☐Pregnant	at time of d		Other (spe						Month	Day Ye	ear
P.O.	The law requires that the death certific ite hes been signed by the attending p lage 2 should be detached for use as	Phy	9 Unknown Part II. Ofher significar	nt conditions co	ontobuting to death	hut not res	utting in the u	nderlying ca	ause ave	n in Part I		23e Did tol	nacco use	contribute to ti	ne cause of de	ath?
ds,	signe d be c	d by	chitic		r fic			idenying oc	2030 GIVE	minir diti.			s 2,527N		ably 4 Ur	
COL	w requir been si should	lete	10 (1000)	tensi		- (						24a. Was a	n 2	4b. Were auto	nsv findings a	vailable
Re	The lav	ompleted	- alffine	7 - 50(1								autops perform	med?	prior to co death? 1 \( \text{Yes}	mpletion of car	use of
ital		O	25. Was case referred	to medical						26. Place	of Deatl	1 ☐ Yes :		1 163	2010	
> \	8 o D	To B	examiner?				ER/Outpatier			r: 4 □ Nu	rsing Ho	me 5 Reside	ence 6	Other (Specif	y)	
Division of Vital Records,	ding Phi th. After thi funeral	ion:	27. Manner of Death 1 Natural 5	Pending	28a. Date of It (Month, I	njury Day Year)	28b. Time of Injury		Bc. Injury Work			28d. Describe ho	w injury o	ccurred		
isic	Attending r death. ector: After by the funer	icat	2 Accident 3 Suicide 6	investigation Could not be	28e. Place of	Injury - At he	ome farm str	M eet factory		′es 2 □ l		28f. Location (St	reet and N	lumber or Rura	l Route Numb	Ar .
Ω	efter Dire	Certification;	4 Homicide	determined	building,	etc. (Specil	y)	00., 100.01,	, 000			City or Town				.,
	To the Hospital or Attent within 24 hours efter deatl To the Funerel Director: completely filled in by the	edicai C	29a. Certifier (Check only one)	Certifying Phy Medical Exam	/sician: To the be iner: On the basis and manney	of examina	wledge, deatl	occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, th occurr	and due to the cared at the time, d	ause(s) and ate and pla	d manner as si	tated. the cause(s)	1.000
	o the	Me	001 01 1 1 4 141-	vol certifier	-0-1			29c.	. License	number		2	9d. Date s	igned (Month,	Day Year)	
	->-0		) (L	KW	114	mo			I	)418	0/18		10	/24,	12006	,
	3		30. Name and address	of person who	ompleted course o	f death (Item	1 23a) (Type	Priorit)	u I	5/ml	PS	, Annap	olis,	m 9 2	21401	
	Sta	te	31. Date filed (Month, D	Day, Year)	32 Regi	strar's Signa						·				
	Registr	ar	00	1 20 70	UD CO	w l	X do	all I								

DHMH 17 Rev 1/2001

**ORIGINAL** 

	•	For State Registrar	State of	Maryland		artment of I		nd Mental	Hygien	0000	35782
4-10	\$	Decedent's Name (First, Mid	dle, Last)					2. Date Mont	of Death	ay Year	3. Time of Death
Physic /Med		VIRGINIA	A. FLYNN						BER 25,	2006	2:55 A M
Exami		4a. Facility Name (If not institut				4b. City, Town,			4	c. County of Death	
4	<b>4</b> 1.	WASHINGTON AD		TAL 7. Age (In yrs. las	et hiethelaul	TAK	OMA PARI		of Birth	MONTGOMER	Y hplace (State or Foreign
Funeral Director		5. Social Security Number 026~1.6~2424	1 M 2 M F	83	Yrs.	Months Days		Min. (Mont	h, Day, Yea	1923 MASS	untry)
		Usual Residence of Decedent						12Dit	O111(1 2)		
how		10a. State 10b. Coun	ty	10c. City,	Town or Lo	ocation					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
889-f	Director		TGOMERY			SILVER S	PRING		1.0		
with th		10e. Street and Number	TTOU COUPT			10f. Zip Code	.001		10g. C	Citizen of What Co	untry?
eath y	era	12705 CASTLEL		dent Ever in U.S.	13		1904 Hispanic Orig	in? (Specify Yes	or No-	U.S.A.	ncan Indian,
ore, Maryland 21215-0036 s. 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23a or 28e-f show other traumatic event, it a Madical Examinat must be notified at	by Funeral	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorce	Armed Fo 1 ☐ Yes If Yes, Giv	rces? 2[X]No e	1	Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 🖾 No		Puèrto Rican, et	c.)	Black, White	e, etc. HITE
5-0036 72 hours at nature!; or older Exam	ted		ent's Education		16a. Dece	dent's Usual Occu	pation	of working	16b.	Kind of Business/	Industry
215 thin 7	Completed	Elementary/Secondary (0-12	nest grade completed) College (1	-4or 5+)	life.	DO NOT use retire	ed)	or Horning			
d 21214 filed within 7 Hygiene. other than "r	Con	12				HOMEMAKER	40.14-15	de Nieuwe /Fired A		OWN HOME	
be fill Had Had out	Be	17. Father's Name (First, Middle						's Name (First, N		an Sumame)	
should b	2	LLEWELLYN  19a. Informant's Name/Relatio			19h Maili	no Address (Stree		ELLEN BATT		or Town, State, Z	in Code)
Maryland nd 2 should be file lith and Mental Hy 27 is marked oth										IG. MARYLAN	
re, M 1 and 3 1 Health tem 27 other tra		NICHOLAS F. FLYN  20a. Method of Disposition	N - SPOUSE	20b. Pla	ce of Dispo	osition (Name of matory or other pla		Date Date		Location - City or	
Pages nent of Pants if it		1 ☑ Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other		State		EAVEN CEMET		10/30/2006	SIL	VER SPRING	- MARYLAND
Baltimore, sermit. Pages 1 a Department of Her important: If item on Injury or other once.		21. Signature of Funeral Service		•	2:	2. Name and Addr	ess of Facility	/			
		1 (Imande	2 Kudel	ug	1	IINES-RINAL 1800 NEW H	AMPSHIR	E AVENUE,	SILVER	SPRING, MA	RYLAND 20904
Physician /Medical		23a. Part1. Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death)	ist only one cause on e	aused he death. ach lide. or as a conseque	My	oc Ard (	_			)	Approximate Interval Between Onset and Death
8760, sate be executed was hysicien and the burial-transit	ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С.	or as a conseque		•					
BOX 6. death certific e ettending p d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	1 ☐ Live b	come of pregnand inth 2 Fetal cant at time of deal own	death 3	□Ectopic pregnand □ Other (specify)	Ey .			23d. Date of del Month	ivery Day Year
ecords, P.O law requires that the es been signed by th	þ	Part II. Other significant cond	itions contributing to de	eath but not result	ting in the u	inderlying cause g	iven in Part I.	23e		o use contribute to 2 No 3 Pr	the cause of death?
~ · · ·	Completed							24a.	Was an autopsy performed?	prior to death?	itopsy findings available completion of cause of
f Vital F ysician: Th is certificate director, pag	Be C	25. Was case referred to med examiner?	cal				26. Place	of Death (Check	only one)		
of Vita Physician: rthis certific ral director,	2	1 ☐ Yes 2 No	-		R/Outpatie	III JUDA	-			6 ☐Other (Spe	cify)
Jing P	on:	27. Manner of Death 1 Natural 5 ☐ Pen	ulig	of Injury th, Day Year)	28b. Time o Injury	W		1	cribe how in	jury occurred	
ne att	Certification:	Z Accident Inve		of Injury - At honing, etc. (Specify)	ne, farm, st	M 1 [	Yes 2 N	28f. Loca	tion (Street or Town, Sta		ural Route Number,
Hospite 4 hours Funerel	edical Ce		ying Physician: To the al Examiner: On the b								
To the within 2 To the complet	Med	29b. Signature and title of cert					nse number	A.	1	Date signed (Mont	h, Day, Year)
6		- Long and	1 1/1/2	OK IN	10	H 3	607	P	10	0-25.	-06
Ψ		30. Name and address of per	on who completed caus	se of death (Item	23а) (Туре	rint)		no Par			
3		Steven Full	les 760.	e CAra		NO. 1	Acos	no fan	nk	WD	
S Regis	tate trar	31. Date filed (Month, Day, Ye	ar) 2006 32.	egistrar's Signat	7 1	porti					

		_ For	State of M	aryland / Dep	artment of h	lealth and M	-	•	
Physicia	an	State     Registrar     Decedent's Name (First, Middle, L	,	Ce	ertificate of	Death	2. Date of Death Month	Day Year	3. Time of Death M
/Medic Examin		Helen Reid Foste  4a. Facility Name (If not institution, g.				or Location of Death		24 2000 4c. County of Dea	ith
	*		onal Medi	CAI Center	+	bury If Under 24 Hrs.	Lo Ditt. (Bit)	Wicomi	
Funeral Director		5. Social Security Number 76. 229–28–3680  Usual Residence of Decedent	1□M 2XE	ge (In yrs. last birthday 32 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Sept 14	Year) C	thplace (State or Foreign ountry)  NC
Maryland f show ied at	lor	10a. State 10b. County  MD Wicom	ico	10c. City, Town or L					10d. Inside City Limits 1   Yes 2   No
with the 3a or 28a	I Director	10e. Street and Number 300 Lemmon Hill			10f. Zip Code 2180	)1	10	g. Citizen of What C	ountry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inmportant: I fire XT is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2\frac{2}{1} If Yes, Give Year or Dates:	Ever in U.S. 13.	. Was Decedent of H If Yes, specify Cub		pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi	
2 should be filed within 72 hours and Mental Hygiene. B marked other than "natural", "aumatic event, the Medical Exa	Completed	15. Decedent's I (Specify only highest g	rade completed)	(Giv	edent's Usual Occup re kind of work done DO NOT use retire	during most of work	king 1	6b. Kind of Business	/Industry
ed with ygiene ier tha t, the i	Com		College (1-4or t	0+)	Tead			Board of	Education
ntal Hy ed oth	Be	17. Father's Name (First, Middle, Las	st)				ne (First, Middle, M	laiden Surname)	
should and Me mark umatic	2	Charles Reid  19a. Informant's Name/Relationship	(Type. Print)	19b. Mai	ling Address (Street	Maude H		City or Town, State,	Zip Code)
and 2 ealth a n 27 is er tra		Doris Martin/sist	er		3 Allen Ro	d., Eden,			
Pages 1 nent of Hi nt: If iter		20a. Method of Disposition  1 XBurial 2 Cremation 3 4 Donation 5 Other (Spec		Henry's	position (Name of ematory or other pla			eloc. Location - City or ${\sf Belmont}$ , N	
permit. Departn Importa any inju		21. Signature of Funeral Spice Lice	aldres		Lewis N. V	ess of Facility Vatson Fu	neral Hom	ne	
Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or co- shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as	d the death. Do not eine.  A ESTIVE a consequence of):  V D a consequence of):  LENAL	HEART FAILUR	FAILU	or respiratory arre	st, 21001	Approximate Interval Between Onset and Death
n certificate be inding physicia use as the bur	Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d23c. If yes, outcome	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of de Month	livery Day Year
uires that signed b	d by Pr	Part II. Other significant conditions  DIABETES	-	-	underlying cause giv	ven in Part I.	23e. Did toba		o the cause of death? robably 4  □Unknown
sician: The law requires that the death certificate has been signed by the atterector, page 2 should be detached for	Complete	HYPERTENSI					24a. Was an autopsy perform 1 Yes	prior to	utopsy findings available completion of cause of
sician certifi irector	Be	25. Was case referred to medical examiner?  1 ☐ Yes	Hospital: 1 mpatis	ent 2 ☐ ER/Outpatie	ent 3 DOA Oth	ner.	th (Check only one		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director.	tion: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigati	28a. Date of Inju (Month, Da	ıry 28b. Time	of 28c. Inju Wo		28d. Describe how	nce 6 Other (Spender injury occurred	ecity)
al or Atter after dea i Director d in by th	Certification:	3 Suicide 6 Could not determine	a Zoe. Flace of in	ury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
e Hospita 124 hours e Funera	Medical C		Physician: To the best aminer: On the basis of and manner st	of examination and/or i					
To th withir Comp	Me	29b. Signature and title of certifier			29c. Licens	63199,		d. Date signed (Mon	th, Day, Year)
200		30. Name and address of person wh	614 E. SHOI	@ N 3	e, Print)				
Sta Registr		31. Date filed (Month, Day, Year) OCT 2 6	2006 32. Registr	rar's Signature	Societ :				

DHMH 17 Rev 1/2001

			1 - For State Registrar	State o	f Marylar	nd / Dep		t of H	lealth a		fental Hyg	iene	6	3578	94
2	n kap		Decedent's Name (First, Middle, Last)     2. Date of Death										3. Time of D	leath	
	Physic /Medi		INUN SITETAM PINCHAM ID								Day 11, 20	Year 106	11:50	р <sup>М</sup>	
	Exami								Location o	of Death		4c. County			
		4	Laurel Regio	nal Hospi	tal		]	Laure	<b>e</b> 1			Prin	ice 0	George's	3
6	Funeral		5. Social Security Number	6. Sex 1⊠ M 2 ☐ F	7. Age (In yrs.		If Under Months	1 Year Days	If Under :	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birtho	place (State or F	Foreign
	Director		215-05-8980 Usual Residence of Decedent	143 W 2 0 1	91	Yrs.					July 8,			ington,	, DC
	MC M		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							Od. Inside City	Limite
	Mary	ō	Manusland Dudne	e George'									'	1 ⊠ Yes 2	
	n the Maryland r 28e-f show	Director	Maryland Princ  10e. Street and Number	S	College	10f. Zip				10	g. Citizen of W	that Cour			
	23a or	٥	9214 Dewberry	Lano			102.	207	7.4.0					itryr	
	death with the Maryland ms 23a or 28e-f show mat be notified at	Funeral	11. Marital Status	12. Was Dece	dent Ever in U	l.S. 13.	Was Deced			ain? (Soe	ecity Yes or No-	U.S.A		can Indian.	
9			1 ☐ Never Married 2 X Marri	Armed For ed 1 ⊠Yes	2 🗆 No					Puerto	ecify Yes or No- Rican, etc.)		c, White,		
03		b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or Da	e ites: WWI	I	1 🗆 Yes	2 No	Specify:			Specify:	V	Thite	
5-0036	72 hours "natural",	Completed	15. Decedent' (Specify only highes			16a. Dece	dent's Usua kind of wo	al Occupa	ation —	of work	1	6b. Kind of Bus	siness/in	dustry	
2121	d within giene. r than "	du	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT u	se retired,	) -						
7	ygier ygier her ti		12			Commer	icial	Real			raiser	Self		oyed	
ng	be fi	Be	17. Father's Name (First, Middle, L								(First, Middle, M		1)		
Z	Mer Mer Marke	ျ	John William		Sr.						Buckingh				
Maryland	12 should be filed within hand Mental Hygiene. 7 Is marked other than "traumatic event, tra Mus		19a. Informant's Name/Relationsh								l Route Number,				
	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked othe any injury or other traumatic event, ang.	18	Patricia A. F	incham -					Lane		ollege Pa				0
Baltimore,	ges it of t		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation			Place of Dispo cometery, crer	natory or o	ne of ther place	9)	D	ate 2	Oc. Location - C	ity or To	wn, State	
ij	tmen tant		4 □ Donation 5 □ Other (Sp		Fo	rt Linc	oln Ce	meter	У	10/1	6/2006	Brentwo	ood,	Maryla	nd
Bal	Deporting Control of C		21. Signature of Funeral Service L	icerisee	X.	//	. Name an				asch's Fu				
	do z e d		14 Cons	lance	1Jas						enue, Hya		le,	MD 2078	1
п			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between	en	
	Physician		Immediate Cause (Final disease or condition	. B:	radycar	dia								Onset and Dea 6 Hours	
	/Medical Examiner		resulting in death)	- W.	Due to (or as a consequence of):									o modelb	
8	LXammer		Sequentially list conditions.		astroin		al He	morr	hage					24 Hour	S
	pe si	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (d	Due to (or as a consequence ot):										
	and tran	Cam	that initiated events resulting in death) Last	c											
8760,	cate be executed only sicien and the burial-transit	icai Examiner		Due to (d	r as a consequ	uence of):									
87	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit			d	_			-					-		
9 x	ding dise as	/Me	IF FEMALE:	220 16 1120 2110											
Вох	leath certifica attending ph	Physician/Med	23b. Was decedent pregnant in the past 12 months?		th 2 Fetal	death 3	Ectopic pre					23d. Date Mont		ry Day Yea	Nr.
	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknov	nt at time of de wn	eath 5∟	Other (spe	ecify)				(VICIA)		Day 16a	3
P.0	thet the de ned by the a detached f		Part II. Other significant condition	Is contributing to dea	ath but not rest	ulting in the un	derlying of	LUCO CINCO	n in Part I		220 Did tobo	202 1122 2021		e cause of deat	
of Vital Records,	signed be del	Δ		atti di da d										e cause of oeat ably 4 ⊠Unki	
Ö	w requir	ete									1 (63	2 140 3		abiy 4 KJOIIKi	nown
3e	has has	Completed									24a. Was an autopsy	ori	or to con	sy findings ava	ilable se of
a											performe 1 ☐ Yes 2∑		ath? ] Yes :	2 □ No	
Vit	Physicien: Th this certificate ral director, pag	<b>m</b>	25. Was case referred to medical examiner?	Hospital:							Check only one)				
ō	Phys this ral dii	٠ <u>۲</u>	1 ☐ Yes 2 ☒ No 27. Manner of Death	1 (XLIN	patient 2 1				4   14013		ne 5 Residen			)	
	ding After	Lio Lio	1 ⊠Natural 5 ☐ Pending	28a. Date of (Month	Day Year)	28b. Time of Injury		Bc. Injury			8d. Describe how	injury occurred	1		
Division	or Attending after death. Director: After in by the fune	Certification:	2 Accident investigated and Suicide 6 Could not	1.50	f Injury At ho	m = fat	M	1 Yes 2 No							
<u>&gt;</u>	2 # 5 C	Ħ	4 Homicide determin	building	f Injury - At ho g, etc. <i>(Specify</i>	nie, iarm, stre	eet, factory,	опісе		2	8f. Location (Stre City or Town,	et and Number State)	or Rural	Route Number,	
_	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the		29a. Certifier 1 X Certifying	Physician: To the	act of my know	uladaa daath									
	24 h	edicai	(Check only 2 Medical E.	Physician: To the base kaminer: On the base and manner	is of examinat	ion and/or inv	estigation,	in my opi	nion, death	place, a occurre	nd due to the cau d at the time, date	se(s) and manr and place, an	ier as sta d due to	ated. the cause(s)	
	o the		29b. Signature and title of certifier		, stated.		29c.	License	number		29d	. Date signed (	Month F	lav Vaarl	
	⊢ s ⊢ ō		) July	your	~					_		-			
		-	30. Name and address of person w	ho completed sevi	of death //-	222) /7: 5	Print'					Octobe:	r 13	, 2006	
15	)		David Alica in	10721	/ / :H	Loan (Type, F	L	+ 01	4,,, <	1.1	200/01	· ( 10 )	1	412/11-	
The second	Sta	te_	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signat	ure for	uxen	1 //	wyo	4118	20000141	NEIG MY	a, x	1044	
- 4	Registra		OCT 23 20	16 hear	J.	Speed					200 COlu.				

			1 - For State Registrar	State of Mar		artment of F			giene Reg. No. 2 (	006	3578
26	Physici	an	1. Decedent's Name (First, Middle					<ol><li>Date of De Month</li></ol>	ath Day	Year	3. Time of Death
4	/Medi		John Bernard	Findley				Octob	er 16,		11:30 p M
	Examir	ner	4a. Facility Name (If not institutio		г		Location of Death		4c. County		-
	Funeral		7959 Telegraph 5. Social Security Number		In yrs. last birthday)	Severn If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da	Anne	9. Birthp	lace (State or Foreign
ь	Director		217-36-9592	1X M 2□F 6	6 Yrs.	Months Days	Hours Min.	(Month, Da	13 <b>,</b> 1940	Wash:	ington, DC
	pu »		Usual Residence of Decedent  10a. State 10b. County	11	0c. City, Town or Lo	ocation				1	0d. Inside City Limits
	faryla shoved ed at	ē				Joanon					1 ☐ Yes 2 ☑ No
	the N 28a-1 notifil	rect	Maryland Anne A	Arundel S	evern	10f. Zip Code			10g. Citizen of	What Coun	**
	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notified at	Funeral Director	7959 Telegraph	Road - Lot 12	.5	21144			U.S.A.		
	deatl	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?		Was Decedent of H	ispanic Origin? (Spo an, Mexican, Puerto			ce - Americ	
99	or Ite	y Fu	1 ☐ Never Married 2 ☒ Mar	ried 1 ☐ Yes 2 📉 No		1 ☐ Yes 2 X No	Specify:	riidari, etc.)	Specif	ck, White,	
215-0036	hours ural"; al Exa	d by	3 Widowed 4 Divorced	Year or Dates:		dent's Usual Occup				WILL	
15	in 72 "nat	olete	(Specify only highe	nt's Education est grade completed)	(Give	kind of work done of the NOT use retired	during most of work d)	ing	16b. Kind of B	usiness/inc	lustry
212	yiene, r thar the N	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Manager	,		Cummin	s Die	se1
פָּ	al Hyg othe vent,	BeC	17. Father's Name (First, Middle,	Last)			18. Mother's Name			ne)	
<u>/lar</u>	Menta	P	James Aloysius	Findley			Rose Elle	en Noak	es		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relations	, , , ,			and Number or Run				,
, <u>–</u>	1 and Health Sm 27 ther t		Rosalie Grace 1				n Road - I	Lot 125	, Sever:		
Baltimore,	ages int of h		1 ☑ Burial 2 ☐ Cremation	3 Hemovai from State	20b. Place of Dispo					•	
Ħ	iit. Partme	l	4 □ Donation 5 □ Other (\$ 21. Signature of Funeral Service		Fort Linc	OIN Cemeter  2. Name and Addre					
Ва	permil Depar Impor any ir once,			1/2/1/2019			imore Ave		Funeral		
	100		23a. Rari1. Enter the disease, o	r complications that caused the conly one cause on each line.						1	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition		phaei	is Ca	ncer	meta	stetic		Onset and Death
	/Medical		resulting in death)	Due to (or as a c	. 0						
	Examiner		Sequentially list conditions,	b							
	ed sit	ine	Sequentially list conditions,	Due to (or as a c	consequence of j						
	death certificate be executed e attending physician and d for use as the burial-transit	ical Examiner	that initiated events resulting in death) Last	cDue to (or as a c	consequence of):						
3760,	e be e sician buris	la E									
89	ifficate g phy as the			0.							
Вох	e law requires that the death certifica has been signed by the attending ph je 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf 1 ☐Live birth 2 [		∃Ectopic pregnancy	,			ite of delive	,
Э.	ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at tin		Other (specify)			Mo	onth	Day Year
P.0	requires that the een signed by the nould be detache	Phy	9 Unknown				ee in Doct I	oo- Dida			ne cause of death?
Š,	ires the signeral signeral be d	þ	Part II. Other significant conditions of the BRAIN	440 \$0	m Esa	o Alves	A CAA	236. Dia t			pably 4 Unknown
Records,	requisionic	Completed by	UR!!!	8,3	77-1 230	8	-//	-			
Rec	The law ate has bo bage 2 sh	Idm						24a. Was auto		prior to cor death?	psy findings available mpletion of cause of
			25. Was case referred to medica	af			Of Disease f Desti	1□ Yes	2 No	1 ☐ Yes	2 □ No
>	Physician: this certificatal director,	To Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	2 ☐ ER/Outpatier	nt 3 DOA Oth	_26. Place of Deatler: 4 □ Nursing Ho			ner (Snecifi	w)
	ig Phy ter thi	ايا	27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. Time o	f 28c. Injur Wor			how injury occur		·/
ior	Attending r death. ector: After oy the funer	atio	Z LLI Accident	gation	car) injury		Yes 2 □ No				
Division	r Att	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern		- At home, farm, str (Specify)	reet, factory, office		28f. Location ( City or To	Street and Numi vn, State)	ber or Rura	I Route Number,
Ω	To the Hospital or Attending Physician: Within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	S	00-0-00 ATT	- Division Table has define	Imprising day of the	h	- determination		()		
	Hosi 24 ho Fune Fune	Medical	29a. Certifier 1 Certifyi (Check only 2 Medical	ng Physician: To the best of r Examiner: On the basis of examiner stated	xamination and/or in	n occurred at the til nvestigation, in my d	ne, date and place, ppinion, death occur	and due to the red at the time,	cause(s) and m date and place,	anner as st	ated. the cause(s)
	o the	Mec	29b. Signature and title of contific	1 1	u	29c. Licens	e number		29d. Date signe	ed (Month,	Day, Year)
	r s r o		> Val	Kun	m. N	l l	05877	19	October	17	2006
1	14)		30. Name and address of persor	who completed cause of deat	th (Item 23a) (Type,				octobel	1/9	2000
14	- 0		Karl Kasamon, M		ital Drive	e, Glen B	urnie, Ma	ryland	20161		
	Sta	ate	31. Date filed (Month, Day, Year	006 2. Registrar's	s Signature	D					

		•	For State Registrar	State of Ma	ryland				lealth a	and M		giene 006	35786
			1. Decedent's Name (First, Middle, Las	t)							2. Date of Dea	ath Day Yea	3. Time of Death
	Physici /Medio		Herley William	n Fike							10	30 01	0 11:38 A.M.
	Examir		4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location o	f Death	ı	4c. County of D	
			WMHS - Brad		Amp		If Under	<u>m</u> ر	ORI (	200	0 Data -4 Bin	AlleGi	
	Funeral		5. Social Security Number 6. Social Security Number 1	ex 7.Age	(In yrs. las	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da	y, Year)	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		86						Feb. 1	8, 1920 P	arsons, WV
	yland yland		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
	Mar.	tor	WV Minera	11		Key	ser						1 ☐ Yes 2 No
	or 28	Sire	10e. Street and Number				10f. Zig	Code				10g. Citizen of What	Country?
	23a	la	80 Hummingbird S					267					SA
	er de	Funeral Director	11. Marital Status	12. Was Decedent Ex Armed Forces?		13.	Was Dece If Yes, spe	dent of H cify Cuba	ispanic Orig in, Mexican	gin? (Spe , Puerto l	cify Yes or No Rican, etc.)	- 14. Hace - A Black, W	mérican Indian,* hite, etc.
36	rs aff	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	,		1 🗆 Yes	2 <b>∑</b> No	Specify:			Specify:	White
21215-0036	i within 72 hours after death with the Maryland liene. r then "netural", or iteme 23a or 28e-f ehow the Madical Examiner munt be notified at	ed	15. Decedent's Ed	ucation		16a. Dece	dent's Usu	al Occupi	ation			16b. Kind of Busine	
215	within 73 ene. then "no	ple	(Specify only highest gra	de completed) College (1-4or 5+	.)	(Give lite.	kind of wo DO NOT u	erk done d se retired	during most ()	t of workii	ng		
21	giene er the	Completed	8				Carma	n				Rail	road
pu	be filed htal Hygi od other event, I	Be (	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,	Maiden Sumame)	
yla	should be ind Mental imarked umatic ev	၉	Earl E. Fike								Mae Jen		
Maryland	12 sho n and r is m raum		19a. Informant's Name/Relationship (7									er, City or Town, State	9236
	s 1 and 2 should I Heelth and Men item 27 is marks other traumatic	1 8	Janet J. Fike/ Ht 20a. Method of Disposition	isband	20b. Pla	ce of Dispo	sition /Na	me of			Keyse	20c. Location - City	or Town, State
2			1 X Burial 2 ☐ Cremation 3 ☐		l _	netery, crei	_				ov. 5		
Baltimore,	in the state of		4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Licen		Poto				Gardet ss of Facilit		2006 	Keyser, V neral Home	V V
Ba	Pen Pen Pen Pen Pen Pen Pen Pen Pen Pen		1 Baines	Frutti	5	1				Sin	Keyse		6726
			23a. Part1. Enter the disease, or companies the companies of the companies			Do not ent							Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a	YOV	<u>e</u>							5 days
	Examiner				Conseque	rice or <sub>j</sub> .							
1		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	conseque	nce of):							
, A	cuted nd ransil	Examine	Cause (Disease or injury that initiated events	c.									
Ö,	s be executed sicien end burial-transit		resulting in death) Last	Due to (or as a	conseque	nce of):							Y
8760,	~ ~ w	dicai		d		<del>.</del>							
9 x	ding p	/Med	IF FEMALE:	23c. If yes, outcome o	f pregnanc	ev.						22d Date of	deliner
Вох	leath certifica attending phi i for use as th	cian	23b. Was decedent pregnant in the past 12 months?	1□Live birth 2	Fetal d	eath 3	Ectopic p		,			23d. Date of Month	Day Year
o.	at the de by the a tached i	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown			2 - 11101 (4	//				J.	
σ.	s that ned b	by Pt	Part II. Other significant conditions of	4.0	t not result	ing in the u	nderlying	ause giv	en in Part I.		23e. Did to	obacco use contribute	to the cause of death?
rds	quires on sign uld be	Pa Pa	Atrial fibr	illation,	( N	edio n	20 P	-fh	7_		10	Yes 2□No 3⊡	Probably 4 Unknown
Records,	law requas been 2 shoul	ompleted	Hyper ten				0.	C			24a. Was	an 24b. Were	autopsy findings available to completion of cause of
Ä	The lay	E									perfo	ormed? death	?
Vital	Physicien: r this certifica ral director, p	BeC	25. Was case referred to medical examiner?	VE-01111	-					of Death	(Check only o	one)	
of V	Physic this co	၉	1 ☐ Yes 2 ☐ No	Hospital: 1 ⊟Inpatien		R/Outpatier			4 🗆 140			dence 6 Other (S	(pecify)
Ĕ	ding P. h. After t funera	ü	27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 2	8b. Time o Injury		28c. Injur Wor			28d. Describe t	how injury occurred	
Sic	C 4 . 0	cat	2 Accident investigation 3 Suicide 6 Could not be		n. At hom	o form str	M (act to		Yes 2 □ I		28f Location /	Street and Number of	Rural Route Number.
Division	s efter	Certification;	4 ☐ Homicide determined	building, etc.	(Specify)	ie, iaiiii, sii	eet, lactor	y, omce			City or Tov	wn, State)	ridia riodie ridinos.
	To the Hospital or Attending within 24 hours efter death.  To the Funerel Director: Alter completely filled in by the fune	Medical (		ysician: To the best of niner: On the basis of and manner stat	examinatio								
	within 2 To the comple	Me	29b. Signature and title of certifier	2			29	c. Licens	e number			29d. Date signed (Me	onth, Day, Year)
	0		I fmann, 1	n.1)-			1	156	20	7		october 30	,2006
	6		30. Name and address of person who	completed cause of de	ath (Item 2	23a) (Type,	- · · ·						
	4			un Mar).	- 9	25 f		OP 1	vals	h Ko	ad, Cui	mberland	MD 21502
	Sta Regist		31. Date filed (Month Pay, Year) 2	006 32. Registra	r's Signatu	is.	2845	9					

			For State Registrar	State of Ma	aryland /	•	rtment of Hotificate of L			giene leg. No. 008	35787			
	Physici		1. Decedent's Name (First, Middle, Last)	<b>D</b> 1		G			2. Date of Dea Month	Day Ye				
	/Medic	al	FIGURE 5. Gainer  46 City Town or location of Death							4c. County of D				
1.	Examin	er	2018 Aberdeen I				Croft			Anne Ar	undel			
	Funeral Director		5. Social Security Number 6. Sex		e (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		(, Year)	Birthplace (State or Foreign Country)  ash. DC			
	pu »		Usuel Residence of Decedent  10a, State 10b, County		10c. City, To	own or Lo	cation				10d. Inside City Limits			
	Aaryla I ehov	ō	MD. Anne Arur	ndel	,		Crofto	n			1 X Yes 2 □ No			
	28e-	rect	10e. Street and Number	ido I			10f. Zip Code			10g. Citizen of What	Country?			
	th with	a D	2018 Aberdeen Dri	ve				21114		USA				
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 ie marked other then "nature!, or iteme 23a or 28e-f ehow other traumatic event, the Madical Examinational be notified at	by Funeral Director	11. Marital Status 1  1 Never Married 2 Married  3 WWidowed 4 Divorced	2. Was Decedent Armed Forces? 1 Yes 25 If Yes, Give Year or Dates:			Vas Decedent of His Yes, specify Cubar	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - A Black, V Specify: W	American Indian, Vhite, etc. hite			
21215-0036	72 hou	Completed	15. Decedent's Educ (Specify only highest grade	16	(Give	lent's Usual Occupa	uring most of wo	rking	16b. Kind of Busine	ess/Industry				
121	within ene. then "	ldmo	Elementary/Secondary (0-12)	5+)	Cle	00 NDT use retired; Erk			US Gov	't.				
1d 2	e filed al Hygie other vent,	Be C	17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle,	Maiden Sumame)				
/lar	2 should be and Mental ie marked o	To B	Не	enry Yeac						Florence Catherine Hayden				
Maryland	and raum		19a. Informant's Name/Relationship (Typ		i i					r, City or Town, Star				
ď.	of Health item 27 i		Karen Wilson - Dat 20a. Method of Disposition	ignter	20b. Place	e of Dispo	sition (Name of	!	Date Date	Maryland 20c. Location - City				
TOL	Pages ent of ht: If it		1 XBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1		natory or other place Ll Cemete:	1	24-06	Suitland,	Maryland			
Baltimore,	permit. Pages 1 Department of H importent: If ite eny injury or ot once.		21. Signature of Funeral Service License	103	call	22	Name and Addres		Beall Fun Hwy., Bo	eral Home wie, Mary	land 20715			
.x	A. 1		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that cause e cause on each l	d the death. D	Do not ent	er the mode of dying	g, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Onset and Death			
**	Physician /Medical Examiner project pr	i Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Dilated cardiomyopathy  Due to (or as a consequence of):  Hypertensive heart disease  Due to (or as a consequence of):  Congestive heart failure  Due to (or as a consequence of):											
8760,	ate the	dicai												
.O. Box 6	et the death certifici by the attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ②No 9 □ Unknown	ath 3	Ectopic pregnancy Other (specify)			23d. Date of delivery Month Day Year						
٥.	gned be de	þ	Part II. Diller significant conditions continuously to doubt out for research years and state of the significant conditions continuously to doubt out for research years.							_	te to the cause of death?  Probably 4 Junknown			
of Vital Records,	The law ate has b page 2 s	Completed				-			24a. Was autop perto 1  Yes	rmed? prior deat	e autopsy findings available to completion of cause of th? Yes 2 \( \subseteq \) No			
/ita	Physician: ' this certifica ral director, p	Be	25. Was case referred to medical examiner?	osoital:			Othe	ar	eath (Check only o					
on of	Phys this ral dii	tion; To	27. Manner of Death  1 Natural 5 Pending	1   Inpatient   2   ER/Outpatient   3   DOA   Other   4   Nursing Hotal   Nursing Hotal   28a. Date of Injury (Month, Day Year)   28b. Time of Injury   28c. Injury at Work?   1   Yes   2   No					Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred					
Division	ppital or Attending ours after death. lerel Director: After filled in by the fune	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	HOP	eet, factory, office			n (Street and Number or Rural Route Number, rown, State)						
	Hos 24 h Fur stely	edical C	29a. Certifier (Check only one) \( \) \( \) Certifying Physical (Check only one) \( \) \( \)	ician: To the best ter: On the basis of and manner s	of examination	edge, deat n and/or in	h occurred at the time vestigation, in my of	ne, date and place pinion, death occ	ce, and due to the courred at the time,	cause(s) and manne date and place, and	er as stated. due to the cause(s)			
	To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of certifier	17			29c. License			29d. Date signed (M				
1 / Chwan Cuman / Samin D37250								10/23/2006						
2	(1)		30. Name and address of person who co	MD, 325	Hospit	tal D	rive, Gle	en Burni	e, Maryla					
de j	St Regist	ate rar	31. Date filed (Month, Day, Year) OCT 23 2006	32. Regist	trar's Signature	Spe	N							

State of Maryland / Department of Health and Mental Hygiene = For State Registrar 35788 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death October 19, 2006 **Physician** George Grigsby 4:20a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Hospital Cheverly Prince Georges If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year , Funeral Days 1**∑** M 2□ F Yrs. Director 579-20-7337 83 Dec. 22, 1922 Huntsville, Al Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturst", or Items 23a or 28a-1 show sny injury or other treumatic event, the Medical Examinating to cother treumatic event, the Medical Examinating to cother treumatic event, the Medical Examinating to cother treumatic event. 1 √Yes 2 No Director D.C. Washington, D.C. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20019 4014 Meade Street N.E. United States Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1943-Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced 1945 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Elevator Mechanic Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George W. Grigsby Carrie P. Fleming ျ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary A. Grigsby / Wife 4014 Meade Street N.E. Washington, D.C.
ce of Disposition (Name of Date 20c. Location - City or 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 I Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial Oct. 25,2006 Suitland, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Alexander S. Pope Funeral Homes, P.A. 5538 Mariboro Pike/Forestville, Md. ~101085 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIAC **Physician** /Medical Due to (or as a consequence of): Examiner YPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of): Examiner attending physician and for use as the burial-transit NEUMONIA Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed neec 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has 1☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No investigation filled in by the fu 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 10 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie within 24 } To the Fu 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL DR CHEVERLY MD 20185 CARNELL COOPER 3001 31. Date filed (Month, Day, Year) 22. Registrar's Signature State OCT 24 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene, For Stata Ragistra 06 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 18, Michael Gillick October 2006 9:00 John /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sunrise Montgomery Village Montgomery Village Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 ★M 2 ☐ F Yrs 151-24-6613 72 1934 New Jersey Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rel', or items 23a or 28e-f show Examiner must be notified at 1 ☐ Yes 2 No Maryland Montgomery Bethesda Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7401 Westlake Terrace #1008 20817 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1951 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1962 1 ☐ Yes 2 🔀 No Specify: Specify: þ White 3 Widowed 4 K Divorced "neturel", leted 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Furniture 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary C. Brower John Gillick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) perriit. Pages 1 and 2 shi Depirtment of Health and Importent: If Item 27 is m any injury or other treum once. 14338 Cartwright Way; North Potomac, MD 20878 John M. Gillick III/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Ft. Lincoln Crematory 10/24/2006 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center
11040 Rockville Pike: Rockville, Maryland 20852 21. Signature of Funeral Service Licensee 23a. Part1 Inter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot of heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** a Lung Cancer 9 months disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discussor Highly that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? page certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 🔯 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: 1 Inpatient Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA 0 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After the Hospitel or Attending 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Funerel 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 24 one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie mo D23600 10/20/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5530 Wisconsin Avenue #1125; Chevy Chase, 20815 Bruce R. Kressel, M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 OCT 2 3 Registrar

### 06-08284

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Robert R. Gallucci			State of	Marylan	_		f Health ar	nd Me	ental Hy	/giene			
	Physician/ Reg No 2 Date of Death  Physician/ 1 Decedent's Name (First, Middle,Last)  Reg No 2 Date of Death  Month Day November 2, 2006  1036 hrs									5 3570			
Physiciana Medical Examine					~				l			ear	1036 hrs
Z	KOI	y Name (if not institu					4b. City, Town, o	or Locatio	on of Death	Novembe	4c. County	of Death	
	96 B	ayview Road					Chesapea				Cecil		
Funeral	5. Social S	Security Number	6. Sex	7.	Age (In yrs.	last birthday)	If Under 1 Ye		nder 24Hrs.	8 Date of B	irth(MM/DD/YYY	Y) 9. Bin Foreig	
Director	222-	-52-4047	1 X M	2 F	46	Yr	Months Da	iys Ho	urs Min.	Novembe	r 5, 1959		untry) <b>PA</b>
<u>s</u>	Usual Res	idence of Decedent	hy		Ino City	, Town or Loca	ion						10d Inside City Limits
d tow any	MD	Ceci	•										1 Yes 2 X No
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with ns 23s	11 Marita	Status	12.	Was Decede			as Decedent of H				o- 14. Rac		can Indian, Black,
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5-0036 ed within 72 hour lygiene other than "natu he_Medical Exan	2	12		_	,	FOI	reman				Oi1	Indu	ıstry
21215-0036 uld be filed within 7 Mental Hygiene marked other than e event, the Medica	17. Father	's Name (First, Midd	le, Last)			1	Cilian	18 Moth	her's Name	(First, Middle,	Maiden Surname		
121 d be fil ental B arked went,	Wi11	iam Gallu								cMichae			
D 21 should and Me 7 is man ratic ev		mant's Name/Relation					g Address (Stre ayview R						
s, MD and 2 sho lealth and tem 27 is traumat		od of Disposition	:I\MITE	3	20b.		sition (Name of c		Tiesa	Date Date	20c. Location		.915 Town, State
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiewile Inportant of Health and Mental Hygiewile Inportant: If item 27 is marked other than "natural", or items 23a or 28ar fake injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director		rial 2 Cremat		Removal from	Oldic.	crematory or of				ember '			1.00
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Physician	23a. Part I	Ent the disease, e List only one cau	or complicati	ons that caus	ed the death	Do not enter	mode 1 dy	a ch a	diac or	FIRFOR	est, ck,	SZI	Approximate Interval Between Onset and
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Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. After this certificate that been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the bedical Certification: To Be Completed by Physician/Miedical Certification: To Be Completed by Physician/Miedical Certification:		decedent pregnant ir 2 months?	1 1 1 4	Live birth Pregnant	at time of de	anth	etal death 3	Ecto	ppic pregnar	псу	Month	Đ	ay Year
Box le death c the atten led for us	1 Yes	2 No 9	Inknown 9	=		5 0	her (Specify)						
O. I hat the ed by the etache	- Part II. Otl	her significant con	ditions con	tributing to de	ath but not r	esulting in the	underlying cause	given in	Part I				he cause of death?
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Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in be	one)	2 Medical E	kaminer:On tand	the basis of e manner state	xamination a	and/or investiga	tion, in my opinio	n, death	occurred at	the time, date	and place, and	due to the	e cause(s)
- 3 - 3 E	29b. Signa	ature and title of cert					29c Licen		er		29d Date sign		
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State Registra		NOV 1	3 2006		ilar s Olgrian	F Ages	de?						

		•	For State Registrar	State of Marylan		artment of tificate o		nd Men		ene	006	35792
100	φ. <b>₹3</b> ,		1. Decedent's Name (First, Middle, Last)						Date of Death Month	Day	Year	3. Time of Death
	Physici /Medic		ROBERT NATH	ANIEL HOL	164,	JR.						11:15p M
	Examin		4a. Facility Name (If not institution, give s	treet and number)			, or Location of [				ounty of Death	
			HOLY CROSS HO				R SPR					MERY
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year Months Day		Min. 8. [	Date of Birth Month, Day, Y	ear)	9. Birth	nplace (State or Foreign intry)
	Director		319627071	3	Yrs.			6	1181	194	ZWA	SIT DC
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Lo	cation						10d. Inside City Limits
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	28°-	5	10e. Street and Number			10f. Zip Code			100	a. Citize	n of What Cou	untry?
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	me 2:	Funeral Director		2. Was Decedent Ever in U.			of Hispanic Origin uban, Mexican, F		Yes or No-		Race - Amer	
9	or ite	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No		r Yes, specify Ci 1 □ Yes 2 🛣 N		Риело ніса	n, etc.)		Black, White	
5-0036	ral',	d by	3 ☐ Widowed 4 Divorced	If Yes, Give Year or Dates:		10165 42011	lo Specify:			5/	pecify: BL/	4CK
5	within 72 hours after death with the Maryland ene. then 'natural', or iteme 23e or 28e-f ehow fa Medical Exeminer must be indiffied at	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Deced (Give	tent's Usual Occ kind of work dor	cupation ne during most o ired)	of working	16	Bb. Kind	of Business/I	ndustry
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Maryland	should ind Men in marke umatic	ဥ	ROBERT N HOUGH  19a. Informant's Name/Relationship (Ty)	, –	19b Mailin	n Address (Stre	et and Number	or Bural Bo	BR17	City or T	own State 7	ip Code) 20910
Ma	d 2 sho th and t7 is m traum		JOHNNIE B. HOUGH/				CKLN					
ē	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Department of Heelth and Mental Hygiene. Importent: if Item 27 is marked other then "natural; or iteme 23a or 28e-1 ehow with injury or other traumatic event, the Medical Exemplest must be notified at once.		20a. Method of Disposition			sition (Name of natory or other p		Date	20	c. Loca	tion - City or 1	Town, State
S C	eges ant of it: If II		1 ☐ Burial 2 X Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)					Inol	2000 1	2	30 N 11	E, MD.
Baltimore,	permit. Peg Department Importent: eny Injury o	li	21. Signature Funeral Service Licens		22	. Name and Add	dress of Facility-	TO4.	TP	41011	=S Fil	NERKZ HOME
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>	ysicl is car direc	To B	examiner? 1 ☐ Yes 2 No	ospital: 1XInpatient 2	ER/Outpatien	t 3 DOA	24b		5 Residen	ce 6[	Other (Spec	ıfy)
0	ng Ph ter th nerel		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. In			Describe how			
Ö	uttendir death. ctor: Al y the fu	atic	2 Accident investigation				☐Yes 2☐No					
Division of Vital	or Attending Physician: The law requires that the death certificate be executed tire death.  Urector: After this certificate hes been signed by the ettending physicien and Director: After this partition and in by the tunerel director, page 2 should be detached for use as the burial-transit.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str v)	eet, factory, offic	08		Location (Stre City or Town,		Vum <i>ber or Rui</i>	ral Route Number,
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	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funaral Director: After this certificete his completely filled in by the funeral director, page	Medical	29a. Certifier  (Check only one)  1 Certifying Physical Examination	sician: To the best of my kno- ner: On the basis of examinal and manner stated.	wledge, death tion and/or in	occurred at the vestigation, in m	time, date and p y opinion, death	place, and o occurred a	due to the cau t the time, date	se(s) ar and pl	id manner as ace, and due	stated. to the cause(s)
	ithin ithe	Med	29b. Signature and title of certifier		^	29c. Lice	ense number		290	. Date s	igned (Month	, Day, Year)
	or with		+ 4VVV	1 MAKING W	7)	DOC	633	75	11	10	7/2	00%
^	(4)		30. Name and address of person who co	mpleted cause of death (Item	1 23a) (Type	Print)	<u> </u>	, , ,	/ (	114	312	006
2			MARIA TAYAG	mpleted cause of death (Item  1500 FORE  32. Registrar's Signa	57 G	LENR	D SILV	en s	PRINC	- W	020	910.
1	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture							
	Registi	rar	OCT 26 2006	Barren D.	Open							

State

Registrar

31. Date filed (Month, Day,

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egistrar's Signatur

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Darvis Leon Haskins 1- For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day October 14, 2006 1345 hrs Medical Examiner DARVIS L. HASKINS 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Bethesda Suburban Hospital 9 Birthplace (State or If Under 24Hrs 8 Date of Birth (MM/DD/YYYY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Director 05/17/1981 WASHINGTON, DC 577 06 1200 1 X M 2 25 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location É 1 X Yes 2 No 28a-f show PRINCE GEORGES OXON HILL MD 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? fied at 20745 UNITED STATES 1126 SOUTHVIEW DRIVE #101 23a c notifi Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black, 11. Marital Status Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No 1 Yes If Yes. Give Year 1 Yes 2 X No specify: Widowed Divorced Specify: BLACK 'natural' \$ 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) s 1 and 2 should be filed within 72 ho if Health and Mental Hygiene. If item 27 is marked other than "na rer tranmatic event, the Medical Ex Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 11THSTUDENT EDUCATION 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle, Maiden Surname) partment of Health and Mental F portant: If item 27 is marked nry or other tranmatic event, Be VERONICA GRAY DEREK GREY 19a Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 526 UNIVERSITY DRIVE WALDORF, MD 20602 VERONICA GRAY / MOTHER 20b. Place of Disposition (Name of cemetery, 20c Location - City or Town, State 20a. Method of Disposition crematory or other place 1 X Burial 2 Cremation 3 Removal from State Pages 1 10/23/06 WASHINGTON NATIONAL CEM. SUITLAND, MD Donation 5 Other Specify 22. Name and Address of Facility
MARSHALL'S FUNERAL
4308 SUITLAND ROAD ature of the meral Sary ne HOME OF MARYLAND, INC. SUITLAND, MD 20746 Approximate Interval I. Enter the disease, or complications that caused the death. Do not enter Physician re. List only one cause on each line. Between Onset and /Medical Death a Gunshot Wounds (2) of Head and Hand Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23d Date of delivery IF FEMALE 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy performed? death? Yes 2 ✓ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 ۵ 1 🗸 Yes No 28a. Date of Injury (Month, Day Year) Oct 13, 2006 28d. Describe how injury occurred 28c. Injury at Work? After 27. Manner of Death 28b Time of Injury Certification: Subject shot 2254 hrs Natural 1 Yes 2 V No Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be

: Hospna...
a 24 hours after death
ae Funeral Director: A
and Funeral Director. To the

and manner stated 29b. Signature and title of certifier Lemich 30. Name and address of person who completed cause of death (Item 23a)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c License number

29d Date signed (Month, Day, Year) O.C.M.E. October 17, 2006

or Town, State) 1139 Southern Drive, Oxen Hill, MD

determined

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD.

Registrar's Signature

(Specify) Sidewalk

31 Date filed (M State Registrar

Medical

Suicide

4 V Homicide 29a. Certifier

(Check only

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started

			For State Registrar AMEND#25perIME1	State of Maryland / I	Department of H Certificate of I		ygiene Reg. No. 2006	35795
	Physici	20	Decedent's Name (First, Middle, Last)			2. Date of I	Death Day Year	3. Time of Death
	Physici /Medic	al	Richard Edward  4a. Facility Name (If not institution, give str		4b. City. Town, or	OCTO!	per 14, 2006	6:30 Р. м
1	Examin	er	Potomac Valley Nurs		Rockvi		Montgome	-
	Funeral Director		311-22-0330	7. Age (In yrs. last bi	rthday) If Under 1 Year Months Days	Hours Min. 38. Date of E (Month, June)	9. Birthpl Pay, Year) 13, 1923 Washi	lace (State or Foreign try) Lington, D.C
	ow II		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow			10	0d. Inside City Limits
	Ba-f sh	ctor	D.C.	Wash:	ington			1 AYes 2 No
	23a or 21	Funeral Director	10e. Street and Number 4201 Butterworth Pl	ace N.W. # 102	10f. Zip Code 200		10g. Citizen of What Coun United State	2S
036	d within 72 hours after deeth with the Maryland Jane. I than "natural", or items 23s or 28s-f show the Medical Examinar must be natified at		11. Marital Status 12  1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 □ No If Yes, Give	37	lispanic Origin? (Specify Yes or lan, Mexican, Puerto Rican, etc.)  Specify:	14. Race - America Black, White, 6 Specify: Whi	etc.
21215-0036	within 72 ho ane. than "natur the Medical	Completed by	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12) 12	College (1-4or 5+)	Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired Onfidential	during most of working d)	16b. Kind of Business/Ind	
	Hygent,	Be Co	17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Midd	fle, Maiden Sumame)	
Maryland		To B	Ira Lee Hawes				rwood	
	s 1 and 2 should I Heelth and Mer Item 27 is marks other traumatic		19a Informant's Name/Relationship (Type Debbie Grant/ Gi	reat Niece 3	711 Pleasant	and Number or Rural Route Num Avenue, Ft. S	mith,OH 4566	2
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ref 4 ☑ Donation 5 ☐ Other (Specify)	moval from State George Medic		Sity October 14		D.C.
Balt	permit Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	Tels_		ss of FacilityColumb1a Box 58007 Washi		
	Fnysician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	(/	umoria	ng, such as cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
ı	Examiner	_	Sequentially list conditions, b.	Due to (or as a consequence	aplegia.	2 to necra)	1c Kos10-183	sweeps
	and I-transit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence		0	() po	DME
58760,	icate be executed physicien and s the burial-transit	dical	d.			n	reshired,	19/06
P.O. Box 6	thet tha death certificated by the attending point of detached for use as	Physician/Me	1F FEMALE: 236. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	h 3 Ectopic pregnano 5 Other (specify)	Jan 1	23d. Date ol delive Month	ery Day Year
	9 D 0	۵	Part II. Other significant conditions control	abuting to death but not resulting	,		d tobacco use contribute to th ☑ Yes 2 ☑ No 3 ☑ Proba	
Division of Vital Records,		Completed	Ogleog	007096		24a. W au pe 1 □ Yes	rformed? death?	psy findings available inpletion of cause of
Vita	Physicien: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	spital: 1 🗀 fnpatient 2 🗀 ER/O	outpatient 3 DOA Oth	26. Place of Death (Check onl	y one) esidence 6 ①Other (Specify	d
ion of	ifing After fune	$\vdash$	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury 28b.	Time of lnjury 28c. Injury Wor		e how injury occurred	,
Divis	To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Certification:	3 🗍 Suicide 6 🗎 Could not be determined	28e. Place of Injury - At home, I building, etc. (Specify)	arm, street, factory, office		n (Street and Number or Rural Fown, State)	Route Number,
	is Hospital 24 hours a 16 Funerei I	edical (	29a. Certifier (Check only one)  1. Certifying Physic 2. Medical Examine	cian: To the best of my knowledger: On the basis of examination a and manner stated.	ge, death occurred at the tir nd/or investigation, in my o	me, date and place, and due to the pinion, death occurred at the time	ne cause(s) and manner as sta e, date and place, and due to	ated, the cause(s)
	16	M	29b. Signature and title of certifier	110-100	29c. Licens		29d. Date signed (Month, L	
-	2		30. Name and address of person who com	ipleted cause of death (Item 23a)	(Type, Print)	BLVD Suite	10cr 1 1, 200	7088
			DY A MENDHIR  31. Date filed (Month, Day, Year)		Researd	BLVD Suite	330 Rockvil	le mo
	Sta Regist		OCT 2 3 2006	Server B	goule			

			1 - For State Registrar	State of Mary	-	artment of F			giene 0 0	5 35796
	Physici	an	1. Decedent's Name (First, Middle, L	ast)				2. Date of Dea Month	Day Ye.	3. Time of Death
	/Medic	al	Leon	Hunt		41. O'h. T.	-1	Oct.15,		8:00p. M
	Examin	er	4a. Facility Name (If not institution, g  Ft. Washingto			Ft. Wash	r Location of Death ington	1	4c. County of D	
	Funeral Director				yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	h 9.	Birtholace (State or Foreign Country)
	ryland thow		Usual Residence of Decedent  10a. State  10b. County		c. City, Town or L	(1)				10d. Inside City Limits
	Ba-f s	ecto	MU Prince	beinges 1	Oxon H					1X Yes 2 No
	th with the 23a or 2	Funeral Director	5434 Wasaan	o Blvo		10f. Zip Code	15		10g. Citizen of What いらA	Country?
980	within 72 hours after death with the Maryland iene. rthen "neturel", or iteme 23a or 28a-f show the Medical Examiner must be notified at	ρ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Myes 2 No If Yes, Give Year or Dates:	-	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	tispanic Drigin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, /hite, etc. Hack
2-0	72 ho	eted	15. Decedent's (Specify only highest g		(Give	dent's Usual Occup	during most of wor	king	16b. Kind of Busine	ss/Industry
21215-0036		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life	DO NOT use retired	d)		Dairy	
Maryland	ed la b	To Be	17. Father's Name (First, Middle, Las Wilkins Hunt	st)			hatie	B. Neal	Maiden Sumame)	
Mar.	d d d d d d d d d d d d d d d d d d d		19a. Informant's Name/Relationship Aura Floyd - D	(Type, Print) Walter	196. Maili	ng Address (Street Woodland	- 1	n Hill M	r, City or Town, Stat	_
Baltimore,	Peges 1 an ment of Heal ant: if Item 2 ury or other		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	☐Removal from State -	Ob. Place of Disposer of Competery, cre	osition (Name of matory or other place	ce) \	Date 3 2006	20c. Location - City	or Town, State
Balti	permit. Peg Department Important: any injury o		21. Sign ture of Puneral Service Lic		2	2. Name and Addre		OHN T. RI	HINES FUNINGTON, D.C.	
	Physician /Medical Examiner	Examiner	23a. Parf. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list curioditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. CAR DIO A  Due to (or as a cor  ANOUC  Due to (or as a cor  Serial	nsequence of):  SHOW  Insequence of):  ACC		ng, such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death UN KNOWW  UN KNOWW  UN KNOWW  UN KNOWW  UN KNOWW  UN KNOWW
68760,	<u> </u>	cai	resulting in death) Last	d. Cong	estive	HEAT	VFal	lue		UNKNOCK
.O. Box	it the death certifica by the attending phi tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Hotel   1 ☐ Yes 2 ☐ Hotel   1 ☐ Yes 2 ☐ Yes	23c. If yes, outcome of pr 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify) _			23d. Date of Month	delivery Day Year
<b>Q</b>	es tha igned be de	Ď	Part II. Other significant conditions	contributing to death but no	t resulting in the u	inderlying cause giv	ren in Part I.			e to the cause of death?  Probably 4 Nuckriown
al Records,	The ete h page	Completed						24a. Was a autops perform	sy prior	
Vital	Physicien: This certificet this certificet at director, pr	o Be	25. Was case referred to medical examiner?	Hospital:	- T 50 0	oth	or	th (Check only or		
ō	Attending Physic death.  ctor: After this by the funeral di	-	1 Yes 2 No  27. Manne of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time of Injury	f 28c. Injur Wor	4   Nursing P		ence 6 □Other (S ow injury occurred	ipecify)
Division	- 2	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine			reet, factory, office		28f. Location (Si City or Town		Rural Route Number,
	To the Hospitei or within 24 hours ali To the Funerei Di completely filled in	ledical (	29a. Certifier 1 Certifying F	Physician: To the best of my aminar: On the basis of examinar and manner stated.	knowledge, deat mination and/or in	h occurred at the tir vestigation, in my o	me, date and place pinion, death occu	, and due to the c rred at the time, d	ause(s) and manner date and place, and c	as stated. due to the cause(s)
)	To th To th comp	Me	29b. Signature and title of certifier	110	Æ.	29c, Licens	e number		29d. Date signed (Mo	onth, Day, Year)
R	(5)		30. Name and address of person	mpleted cause of death		Print)			144	00
	Sta Registr		SAMUEL KLEIM 31. Date filed (Month, Day, Year)  OCT 2 0 2006	32. Registrar's S	1			., 201		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2006 10/ Physician Kimolin Giselle Hamilton 16/ 11:39a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 7011 Woodstream Terrace Lanham, Prince Georges | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. 03/04/1969 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 M 20 F 558-57-4005 37 California Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f ehow the Medical Exeminer must be notified at 1 Yes 2 □ No MD Director Prince Georges Lanham 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number or items 23s or 7011 Woodstream Terrace 20706 U.S.A. death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after I □Yes 2 ☑ No f Yes, Give Year or Dates: t Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ≱☐ No Specify: Black þ 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than. Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. Social Worker Goverment permit. Pages 1 and 2 should be filed.
Department of Health and Mental Hygn important: If Item 27 is marked other eny injury or other traument. other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Solomon Hamilton Jr. Eldora C. Niles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yolanda P.Smith/Sister 11144 S.Western Ave.Los Angeles CA.90047 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Inglewood Park 1 Burial 2 □ Cremation 8 □ F 4 □ Donation 5 □ Other (Specify) 3 ☐ Removal from State 10/26/06 Inglewood, CA Cemetery 21. Signature of Full 22. Name and Address of Facility Taylor's Funeral Home 1722 N.Capitol St.NW Washington, DC 20002 2/a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician End Of Renal Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): physician Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Obesity 1 ☐ Yes 2 ☐ No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Diabetes 24a. Was an autopsy performed? Yes 2 No 1□ Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Inpatient Certification: To 1. 10s 2 No 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After the Hospital or Attending s after de-ral Diractor: Atte 1 Natural 5 Pending Injury 1 Tes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Funeral I 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29b. Signature and title of certifie Hospital Drive, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State OCT 2 0 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** NOVEMBER 3, WALTER HOLT 2006 1:16P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Evaminer FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**X** M 2□ F Director 199-16-1108 78 4/18/1928 PA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director NJCape May Ocean City with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 316 East Sea Spray Road 08226 USA Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: 3 Nidowed 4 Divorced White I Hygiene. other than "natura ent, the Medical E 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Publisher Newspaper if Health and Mental Hygiv Item 27 Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter L. Holt Sr. Victoria Barron ပ other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6112 Spring Meadow Lane Frederick, MD 21701 Dennis Holt Son 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 11/4/2006 | Smithsburg, Maryland 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Funeral Service Licenses 106 East Church Street Frederick, MD 21701 M00176 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Acule gastionnestival bleed disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner September variety Sequentially list conditions, if any, leading to firm solute cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit Due to (or as a consequence of) The law requires that the death certificate be exec physician s the burial Physician/Medical 88 attending | IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Dav 5 Other (specify) ed by the a ☐ Yes 2☐ No 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No page 2 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 ☐ Pending investigation (Month, Day Year) Injury Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760. To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completely filled in by the ful

(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

00064741

11/4/06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick Leigh Willows

400 West 7thStreet Memorial Hospital Frederick, MD 21701

State Registrar

Medical

31. Date filed (Month, Day, Year) 2006



### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Day Year OCTOBER MARION CRONHARDT HISLER 29,2006 8:30 AM 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death WALDORF HEALTHCARE Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) WALDORF If Under Year TUnder 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Davs Months Hours 1 M X XF Yrs 262-10-6742 86 JUNE 11,1920 MARYLAND Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No MARYLAND CHARLES WALDORF 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4140 OLD WASHINGTON ROAD 20602 U.S. A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY 12 JOHN HOPKINS HOSP 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MAPTON LENOA MASON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FREDERICK CRONHARDT 19a. Informant's Name/Relationship (Type, Print) P.O. BOX 57, BEL ALTON, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date DORIS A. FRERE-SISTER MARYLAND 20611 20a. Method of Disposition 1 ☐ Burial 2√ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MF. METROPOLITIAN CREMATORY 11-01-05 ALEXANDRIA, VIRGINIA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. M00479 PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death)

**Physician** /Medical Examiner

**Physician** 

/Medical

Director

Be Completed by Funeral

2

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "natural", or tiems 23a or 28a-f show eny hijury or other traumatic event, Ira Medical Examinst must be notified at 2028.

Baltimore, Maryland 21215-0036

burial-transit within 24 hours after death. To the Funerel Director: A

or Attending Physician: The law requires that the death certificate be executed

Hospital

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):	מת
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	kc. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions cont	tributing to death but not resulting in the underlying cause given in Pa	art I. 23e. Did tobacco use contribute to the cause of death?  1 □ Yes 2 No 3 □ Probably 4 □ Unknown
		24a. Was an autopsy performed?  1 Yes 2 No 1 Yes 2 No
25. Was case referred to medical examiner?		lace of Death   Check only one
1 ☐ Yes 2 No	ospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4	Nursing Home 5 Residence 6 Other (Specify)
27. Manner of Death  Natural 5 Pending  Compared investigation	28a. Date of Injury 28b. Time of 28c. Injury at Work?	28d. Describe how injury occurred
3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	ician: To the best of my knowledge, death occurred at the time, date er: On the basis of examination and/or investigation, in my opinion, and manner stated.	e and place, and due to the cause(s) and manner as stated. death occurred at the time, date and place, and due to the cause(s)

29c. License number

D61652

Registrar DHMH 17 Rev 1/2001

completely

Σ

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

NOV 1 3 2006

pleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

06-08274 Sandra Harvey

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 35800

19		Registrar	ertificate of Death	Reg.	No. ZUUt	3580
Physici Medical Exami		1. Decedent's Name (First, Middle, Last) Sandra K. Harvey		Date of Death     Month     November 1	ay Year	3. Time of Death 1841 hrs
Andrew -		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Death	101111110
**		Western Maryland Health System	Cumberland		Allegany	
Funeral Director			. last birthday) If Under 1 Year If Under 24Hr  Months Days Hours Mir		MM/DD/YYYY) 9 Birth Foreign	
Director		220-96-7493 1 M 2 x F 37		7-9-19	69 Cou	ntry) MD
λίυε		Usual Residence of Decedent  10a State 10b. County 10c. Ci	ty, Town or Location			10d. Inside City Limits
Jaryland 28a-f show any	ř	MD Allegany	Cresaptown			1 XYes 2 No
daryla 28a-f 1 at or	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Count	ry?
th the Maryland 23a or 28a-f sho		14200 Cunningham Drive	21505		USA	
ath wit tems 2	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	U.S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto		14. Race - America White, etc.	an Indian, Black,
ter dez	-	3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:		Specify: Wh	ite
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner.	d by	15. Decedent's Education (Specify only highest grade completed)	16a Decedent's Usual Occupation (Give kind of		6b. Kind of Business/Ind	
6 n 72 h an "n ical Es	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use ret	irea)		
OO3 withi	mo	12 17. Father's Name (First, Middle, Last)	Homemaker	e (First, Middle, Maio	OWN (	home
21215-0036 uld be filed within 72 hours afte Mental Hygiene. marked other than "natural", cevent, the Medical Examines	Be C	Ramon E. Harvey, Sr.	· ·	. Lewis	deri damane)	
	2	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Address (Street and Number or			
Baltimore, MD bernit Pages I and 2 shr Department of Health and Important: If item 27 is njury or other traumat		Mary Harvey/mother  20a Method of Disposition 20b	14117 Merla Dr. SW, Place of Disposition (Name of cemetery.	The second second	n, MD 2150	
Ore,		1 Burial 2 Cremation 3 Removal from State	crematory or other place)		,	
ti Page	, A	4 Donation 5 Other Specify: SC 21 Signature of Euperal Service Licensee	arpelli Funeral Home, PA 1	1/5/2006	Cresaptown,	
Balti permit Departm Imports injury o		2 Julian Strong Electrical And And And And And And And And And And	22. Name and Address of Facility Sca 108 Virginia Aven	rpelli Fu ue. Cumbe	neral Home	, PA 21502
Physician		23 all. Enter the disease, complications that caused the deal				Approximate Interval Between Onset and
//////////////////////////////////////		Immediate Cause (Final disease a. Pulmonary throm	boembolism left leg deep vein	thrombosis		Death
		or condition resulting in death)  Due to (or as a consequence	of):			
33	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	of):			
	Examiner	(Disease or injury that initiated events resulting in death) Last	of):			
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be exesician	n/Medical	X unpended $=$ 423a,27,	perMe, g863, 1/11/07 TT			
8760, tificate be ng physic as the bur	n/M	IF FEMALE: 23b. Was decedent pregnant in the	gnancy  2 Fetal death 3 Ectopic pregna		23d Date of delivery  Month Da	y Year
Box 687 death certific the attending of	sicial	4 Pregnant at time of c				,
P.O. Bc that the des ned by the a detached fo	Phy	Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I	23e Did tohac	co use contribute to the	e cause of death?
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ords, w requires been seen seen seen seen seen seen se	ompleted			24a. Was an		psy findings available
eco he law te has	dmc		· · · · · · · · · · · · · · · · · · ·	autopsy performed 1 ✓ Yes 2	d? death?	npletion of cause of
Vital Reco ysician: The law his certificate has director, page 2 s	Be	25. Was case referred to medical	26 Place of Death (Check		10 100	2 110
Vita hysici this c	P	Tes 2 No			sidence 6 Other:	
Division of Vital Records, rate of a Attending Physician: The law requirers after death at Director: After this certificate has been seen in by the funeral director, page 2 should		27. Manner of Death  1 X Natural 5 Pending	28b. Time of Injury 28c. Injury at Work?	28d. Describe how	injury occurred	
isio Atten er deat rector by the	rtification:	2 Accident Investigation 28e Place of Injury - At	home, farm, street, factory, office building, etc.	28f. Location (Stree	et and Number or Rural	Route Number City
Division pital or Attent ours after death eral Director:	Certif	3 Suicide 6 Could not be determined (Specify)		or Town, State		
	Salc	29a Certifier (Check only 1 Certifying Physician: To the best of my knowle	dge, death occurred at the time, date and place, and			
To the Hos within 24 h To the Fut completely	Medical	one) 2 Medical Examiner: On the basis of examination and manner stated.  29b. Signature and title of certifier	and/or investigation, in my opinion, death occurred a			
		250. Signature and title of certified	O.C.M.E.		od. Date signed (Month November 2, 2006	
		30. Name and address of person who completed cause if death (the	, west			
		Theodore M. King, Jr., MD. Assistant Medical	,	e, MD 21201		
St Regist	ate	31. Date filed (Month, Day, Year) 32. Gegistrar's Signa NOV 1 3 2006	ture franks			
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			1 - For State Registrar	State of N	//arylar		artmen			and M		giene Reg. No.	006	3!	58	0
	Physici	an	1. Decedent's Name (First, Middle, La	st)							2. Date of De Month	ath Day	Year	3. T	ime of D	eath
	/Medic		David Edward Ice								Octobe	· T		3:	50	A <sup>M</sup>
}-	Examir	er	4a. Facility Name (If not institution, giver Greater Laurel N				4b. City,	_	Location of	of Death			county of Dear		AC	
20	Euparal		5. Social Security Number 6. S			last birthday)	If Under	1 Year	If Under		8. Date of Bir	th	-	hplace (		Foreign
100	Funeral Director		579-42-6468 Usual Residence of Decedent	<b>\</b> M 2□F	74	Yrs.	Months	Days	Hours	Min.	01/29/	1932	Co	hing		
	arylane show	<u>.</u>	10a. State 10b. County			ty, Town or Lo							-		side City	
	the Ma	Directo	Maryland Prince	Georges	Gle	nn Dal		Codo				10a Citia	\\\		XYes 2	
	with a sa or 3	Dir	12001 Green Court				10f. Zip					USA	en of What Co	untry?		
36	d within 72 hours after deeth with the Maryland Jene. r then "natural", or items 23a or 28e-f ehow the Madical Exeminational be notified at	by Funerai	11. Marital Status  1 □ Never Married   3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Force 1  Yes 2 X If Yes, Give Year or Dates	s? ∭Mo		Was Dece	dent of Hi cify Cuba	spanic Ori n, Mexican Specify:	gin? (Sp n, Puerto	ecify Yes or No Rican, etc.)		4. Race - Ame Black, Whit		lian,	
21215-0036	2 hou	ted	15. Decedent's E	ducation		16a. Dece	dent's Usua	al Occupa	ation	. ,		16b. Kin	d of Business/			
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	alth ar 27 is		Ingrid Icenhower/								nn Dale					
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Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if itsm 27 is marked eny injury or other treumatic enginers.		21. Signature of Funeral Service Lice	nsee							ert E. ad Bowi			ral :	Home	:
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events	one cause on each	line. Catic as a conseq	Merkel quence of):								Interv	oximate val Betwe et and De ar	en ath
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	To the Hospitel of within 24 hours at To the Funeral Discompletely filled in	edicai	29a. Certifier 14 Certifying Pt (Check only one) 2 Medical Exam	nysician: To the be miner: On the basis and manner	of examina	owledge, death ation and/or in-	n occurred vestigation	at the tim in my op	e, date and pinion, deat	d place, th occurr	and due to the ed at the time,	cause(s) a date and p	nd manner as lace, and due	stated. to the ca	ause(s)	
	To t To t	Σ	29b. Signature and title of certifier				290	. License	number			29d. Date	signed (Monti	n, Day, Y	(ear)	
			- Com Not					D432	237			Octob	er 24,	200	6	
	6		30. Name and address of person who Paul Armstrong, N					rive	Suit	a 10°	2 Laure	1. MT	20707			
80%	Sta	te.	31. Date filed (Month, Day, Year)		strar's Signa		LK DI	TVE		_ 10.	L Haure	- PID	20/0/			
	Registi		OCT 25	2006	oda.	to A	eseli	•								

				ate of Maryland				•	•	25002
			State Registrar		Cer	tificate of L	Death		. No.Z U U C	35802
	Physici	an	Decedent's Name (First, Middle, Last)     Dorothy Jackson					2. Date of Death Month	23 200	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street	and number)		4b. City, Town, or	Location of Death	UCTUBER	4c. County of Dea	
	Examin	C1	Baltimore-Washington	Medical Cer	iter	Glen	Burnie		Anne Ara	undel
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) 6/10/15	(ear) 9. Bii	thplece (State or Foreign ountry)
	Director		577-42-7522		Yrs.			6/10/15	Gas	ston Co., N.C.
	yland		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Ba-f	Director	Md Anne Arund	el c	dento	n				1√2 Yes 2 No
	be filed within 72 hours after death with the Maryland tal Hygiene d other than "neturel", or iteme 23a or 28a-f ehow event, i're Medical Exatrian must be multiled a	Dire	10e. Street and Number  2648 Evergreen Roa	4		10f. Zip Code	21113	100	o. Citizen of What C U.S.	
	death me 23	Funeral	11 Marital Status 12. W	as Decedent Ever in U.S.	13. V	Was Decedent of Hi f Yes, specify Cubar		ecify Yes or No-	14. Race - Am	erican Indian,
ထွ	after or ite	/ Fui	1 Never Married 2 Married 1	med Forces? □Yes 2 XNo Yes, Give		i Yes, specify Cubai	n, mexican, ruento Specify:	rican, etc.)	Black, Whi	ie, etc. Black
Ş	hours lural',	d by	3	ear or Dates:			i mi	146	6b. Kind of Business	
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212	giene giene er tha	Completed	Elementary/Secondary (0-12) Co	ollege (1-4or 5+)	Cus	todian		Bo	pard of Ed	ducation
Maryland 21215-0036	S should be filed withir and Mental Hygiene. ie marked other than aumatic event, Ita Ma	To Be (	17. Father's Name (First, Middle, Last) Samuel McVea					e (First, Middle, Ma y Rankin	iden Sumame)	
	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 ie marked eny Injury or other traumatic es	4	19a. Informant's Name/Relationship (Type, Pr Shirley Graham/Niece	rint)					City or Town, State, urnie, Md.	
altimore,	of Her of Her fitem r othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remov	20b. Pla	ce of Disponetery, crem	sition (Name of natory or other place	9)	Date 20	c. Location - City o	Town, State
Ĕ	ment tant: h		4 □Donation 5 □ Other (Specify)	Anna	-	Mem. Gar				, Maryland
Bal	permit Depar Impor eny in		21. Signature of Funeral Service Licensee	Prate						D.C. 20019
ı			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	is that caused the death.	Do not ente	er the mode of dying	such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
).	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	rongestine	he	A tan	line			
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<u>ر</u> م	that the de ned by the a detached f	by Ph	Part II. Other significant conditions contribut	ing to death but not result	ing in the ur	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
rds	e law requires tha hes been signed je 2 should be de	ed b						1 🗆 Yes	2√2 No 3 □ P	robably 4 Unknown
eco	law re es be	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
<u>~</u>	: The cete h							performe 1 ☐ Yes 2	d? death? No 1 ☐ Ye	s 2□ No
<u> </u>	sician certifi rector	o Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospit	al:	7/0	Othe		h (Check only one)		
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ion	ending lath. or: Aft he fun	atlo	1 Natural 5 Pending investigation	(Month, Day 1 Gar)	Injury		res 2 □ No			
Division of Vital Records, P.	Hospital or Attending Physician: The law requires that the death certificat 24 hours after death. Funerel Director: After this certificate hes been signed by the attending phylially filled in by the funeral director, page 2 should be detached for use as the last filled in by the funeral director, page 2.	Certification:	3 Suicide 6 Could not be determined 28	<ul> <li>Place of Injury - At hom building, etc. (Specify)</li> </ul>	e, farm, str	eet, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	lural Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificete he completely filled in by the funeral director, page	Medical (	29a. Certifier (Check only one) Certifying Physician (Check only one)	: To the best of my knowl on the basis of examination and manner stated.	edge, death n and/or inv	occurred at the time restigation, in my op	e, date and place, pinion, death occur	and due to the cau red at the time, date	se(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License	number	290	I. Date signed (Mon	th, Day, Year)
			A A	ms		04	3977	0	Hober 2	23 2006
1	,		30 Name and address of person who completed	RDI Hospital	Du	re Gden	Brum	è.mo	21061.	
	Sta Registi		31. Date filed (Month, Day, Year) (OCT 2 6 2005	32. Registrar's Signatu	Spen	1				

		•	1 - State of Ma		epartment Certificate			nd Mental Hy	giene 006	35803
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Steven David	Jone	25			2. Date of De Month	Day Year	3. Time of Death 7:45 PM
	Examin	er	4a. Facility Name (If port institution, give street and number)  BALIMORE VIA MED		MER	BA	Location of	MORE	4c. County of Pea	7
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 □ F 7. Agr 1 M 2 □ F 8. Sex 1 M 2	e (In yrs. last birth	hday) If Under Yrs. Months	Days	Hours	Min. 8. Date of Bir (Month, Da March 4	1948 Mai	thplace (State or Foreign country) ryland
	aryland show		10a. State 10b. County	10c. City, Town		_				10d. Inside City Limits
	the Marylan 28e-f show	ecto	Maryland Harford  10e. Street and Number		Bo 10f. Zip	elcar	ηp		10g. Citizen of What C	1 X Yes 2 □ No
	h with	io ie	1227 Muskett Court				1017		USA	,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: if item 27 is marked other than "neturel", or iteme 23a or 28e-f show importent: if item 27 is marked other than "neturel", or iteme 23a or 28e-f show injury or other treumatic event, ite Marieal Exercites matter natities at ance.	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Armed Forces? 1 Never Married 2 Married 11. Was Decedent Armed Forces? 1 Never Married 2 Married 12. Was Decedent Armed Forces? 1 Never Married 2 Married 13. Was Decedent Armed Forces?	10	13. Was Deced If Yes, spec	ent of His		in? (Specify Yes or No Puerto Rican, etc.)		te, etc.
215-0036	72 hou	eted	15. Decedent's Education (Specify only highest grade completed)	16a. (	Decedent's Usua (Give kind of wor	l Occupat	tion urina most (	of working	16b. Kind of Business	/Industry
2	filed within Hygiene. other than "	Completed	Elementary/Secondary (0·12) College (1-4or 5		(Give kind of wor life. DO NOT us ertified	Nurs	ses As	ssistant		spital
Maryland	ntal Hy ed oth	Be	17. Father's Name (First, Middle, Last)  Warren S. Jones					s Name (First, Middle,		
aryl	should ind Men s marke umatic	ဥ	19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Address	(Street ar			le Crockson er, City or Town, State,	Zip Code)
	and 2 ealth a n 27 is		Myrtle Jones / mother				Circle		n, Maryland	
Baltimore,	Pages 1 ment of H ent: If itel ury or oth		20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 ☐ Removal from State  1 4 ☐ Donation 5 ☐ Other (Specify)	cemetery	Disposition (Name, crematory or of on Forest	her place	1	10/30/06	20c. Location - City or Owings Mi	
Balt	permit. Departr Importe any inje		21. Signature of Funeral Service Licensee	man	22. Name and L. 5.	isa S	of Facility SCOTT Wis S		ome, P.A. Tre de Grac	
	Physician		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir Immediate Cause (Final disease or condition	10.	ot enter the mode	or arying.	, such as ca	ardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as	a consequence of	f):			,		
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8760,	cate be executed oblysician and the burial-transit	lical E	d	a consequence of	1):					
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	quires that n signed b uld be deta	Completed by Pl	Parll. Other significant conditions contributing to death be Hepatitis C Virus	at not resulting in	the underlying ca	ause giver	n in Part I.	23e. Did t	obacco use contribute to	o the cause of death?
Vital Records,	law requir as been si 2 should l	piete	Chronic Kidney Dise	ease				24a. Was		utopsy findings available completion of cause of
al R	icien: The lav certificate has ector, page 2		\					1 Yes	ormed? death? 2☐No 1☐Yes	
V.	Physicien: this certificatal director,	To Be	25. Was case referred to medical examiner?  No Yes 2 □ No Hospital: 1 Inpatie	nt 2□ER/Outp	patient 3 DO			of Death (Check only o	one) dence 6 □Other (Spe	oihi)
n of	ng Phy fter this	T iuc	27. Manner of Death  Talural  5 Pending  (Month, Day	v 28b. Ti		Bc. Injury	at		how injury occurred	chy)
Division	l or Attendii after death. Director: A I in by the fu	icatio	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	ury - At home, farr	М	1 🗆 Y	es 2∐N		Street and Number or Ri	ural Pouto Number
Di∨	el or A s after il Direction by	Certification:	4 Homicide determined 238. Place of Injury	:. (Specify)	in, street, ractory,	Onice		City or Tov		irar Aoste ivuliber,
	To the Hospitel or Attending Physicien: The lawinin 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edicai C	29a. Certifier (Check only one)  1 Sertifying Physician: To the best of and manner sta	examination and	death occurred a Vor investigation,	at the time in my opi	a, date and nion, death	place, and due to the occurred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To the within To the comple	×	29b. Signature and title of certifier		29c.	License	number	7	29d. Date signed (Mont	
			Xorch, M.D.			/ /	455	3	OCT 20	2006
5	TIVA		30. Name a da dress of person who completed cause of d	atn (Item 23a) (T	ypa, Print)	ne (	St: P	altimore	MD 21	201
-	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 6 2006	ır's Signature	peop		)		, MD 21	

			1 - For State Registrar Amend #20b. 20c.	State of Maryla				_	giene 0	06	35804
4	-		Decedent's Name (First, Middle, Last		0-0001	timodito o	· Dodiii	2. Date of De			3. Time of Death
	Physic		MARY M	ARVIS				Month	Day	Year 2006	2156M
3	/Medi Examir		4a. Facility Name (If not institution, give			4b. City, Town	n, or Location of Death			y of Death	\$130
1			Washington Adven	tist Hospita	1	Takom	na Park		Mon	tgome	ry
	Funeral		Social Security Number     6. Se	7 14 a 170 E	rs. last birthday)	If Under 1 Ye Months Day		8. Date of Bir (Month, Da	th ly, Year)	9. Birthpl Count	ace (State or Foreign
	Director		4/6-18-1320 Usual Residence of Decedent	- 80	Yrs.				-1920		esota
	s 1 and 2 should be filed within 72 hours after death with the Maryland If Health and Mentar Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic avent, the Madical Examinar must be notified at	tor	10a. State 10b. County  Maryland Prince G		City, Town or Lo					10	od. Inside City Limits 1   Yes 2   No
	7 28a	Funeral Director	10e. Street and Number	eorge s 1	iyattsvi	10f. Zip Code	9		10g. Citizen of	What Count	ry?
	h with	a D	5720 39th Avenue	2		2078	1		U.S.A.		
	deat	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	u.S. 13.		of Hispanic Origin? (Spuban, Mexican, Puerto	pecify Yes or No		ce - America	
98	or ft	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 2 🛣 N		rican, etc./		ick, White, e <i>fy:</i> W <b>hi</b> t	
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12	within ene. then "	E C	Elementary/Secondary (0-12)	College (1-4or 5+)		maker	1160)		Own H	omo	
	illed Hygie other	BeC	17. Father's Name (First, Middle, Last)		110	marci	18. Mother's Nam	e (First, Middle,			
lar	Mental:1	To B	Merle C. Mason				Gladys	Crahan			
Maryland	should be filed within and Mental Hygiene.		19a. Informant's Name/Relationship (T)	pe, Print)	19b. Mailir	ng Address (Stre	et and Number or Rui	al Route Numbe	er, City or Town	, State, Zip (	Code)
	1 and 2 Health am 27 i		Charles E. Jarvis	s - Husband	5720	39th_	Avenue, Hy	attsvil	le, MD	20781	
Baltimore,	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F		o. Place of Dispo Tington		1/2001	Date 1-2-06	20c. Location		
Ë	Pag ment ant: I		4 □ Donation 5 □ Other (Specify)	-Fi	ort Line	<del>oln Ceme</del>	tery 10/	1-2-06 <del>17/2006</del>	Arling Brent	rood,	Maryland
3all	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licens	7				sch's F			
	0 □ F € Ø		23a. Part I Enter the disease, or comp	1/01			timore Ave			, MD 2	20781
	Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons	equence of):	e Lufe	uton				Approximate Interval Between Onset and Death
P.O. Box 68760,	Physician: The law requires thet the death certificate be executed this certificate has been signed by the attending physicien and rall director, page 2 should be detached for use as the burial-transit	Physician/Medical Exar	IESEMALE:	Due to (or as a cons  d	gnancy etal death 3	Ectopic pregnar				ate of deliver	√ Day Year
	res thet t igned by be detac		Part II. Other significant conditions co	ntributing to death but not a	esulting in the ur	nderlying cause	given in Part I.	23e. Did to	obacco use con	tribute to the	cause of death?
Records,	quires n sign uld be	d by	Diabetes					101	res 2□No	3 Proba	bly 4 🗷 Únknown
S	w requ	jete						24a. Was	an 24h	Were auton	sy findings available
Re	The law	Completed						autop	rmed?	prior to com death?	pletion of cause of
Vital	an: tifica tor. p	0	25. Was case referred to medical				26. Place of Deat			1 ☐ Yes 2	!LI No
<b>1</b>	nysicia nis ceri direct	To B	examiner? 1 ☐ Yes 2 ☐ No	lospital: 1 Inpatient 2	☐ ER/Outpatien	t 3 DOA	Other: 4 Nursing Ho			ner (Specify)	
n of	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. In		28d. Describe h			
Sio	Attending ir death. ector: After by the fune	atic	2 Accident investigation				☐ Yes 2 ☐ No				
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - Albuilding, etc. (Spe	t home, farm, stre cify)	eet, factory, offic	e e	28f. Location (S City or Tox	Street and Numb vn, State)	ber or Rural	Route Number,
	urs a										
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the ft.	Medicai	29a. Certifier  (Check only one)  1 ☑ Certifying Phy 2 ☐ Medical Exami	sician: To the best of my kener: On the basis of examand manner stated.	ination and/or inv	occurred at the estigation, in my	time, date and place, y opinion, death occur	and due to the ored at the time,	cause(s) and madate and place,	anner as sta and due to t	ted. he cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	1.		29c. Lice	nse number		29d. Date signe		ay, Year)
			Jalujarach:	un, MD			063703		1011	406	
)	(6)		30. Name and address of person who co	ompleted cause of death (I	tem 23a) (Type,	Print) 760	OU CARROL PA	LAU, M	WUE-		
*	Sta	- 1	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	47					
	Registr	ar	nct 2 3 2006	Markey L	7. Open						

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	*		1. Decedent's Nam	e (First, Middle,	, Last)								2. Date of D Month	eeth Day	Yea		Time of Death	
	Physiciai /Medica		EVELY	N D	•	J	ACKS	ON					OCTOBE	R 17	200	6 9	:45 PM	
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В	Funeral Director		5. Social Security N 579-40-8	367	6. Sex 1 ☐ M	2 <u></u> F	7. Age 83		last birthday, Yrs.	Months		Hours Min		ay, Year) 192			(State or Foreign FTON, DC	
	show	Ì	Usual Residence of 10a. State	10b. County				10c. Cit	y, Town or L	ocation							nside City Limits ☐Yes 2 ☐ No	
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020	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. Ortant: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show Injury or other traumatic event, the Medical Evandrat must be notified at a.	֓֡֞֜֞֡֡֡֡֡֡	1 ☐ Never Merr 3 ☐ Widowed			Was Dec Armed F 1 Tes If Yes, G Year or I	2K No		,			lispanic Origin? (S an, Mexican, Puer Specify:	to Rican, etc.)		Black, W			
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lan	lid be ked o	20	FREDERI	CK NEWM	AN							DELL	A SCOTT					
Maryland	should and Men marke umetic	7	19a. Informant's N	ame/Relationsh	ір (Туре,	Print)			19b. Mail	ng Addre	ss (Street	and Number or R	ural Route Num	ber, City or T	own, State	e, Zip Code	a)	
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				MA						7	D1854	45		OCTOB	ER 19	. 260	)6	
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1			PHILIP I	VI SOTSK	Y_M.	0.00	Danistes	de Ciene			RE WA	ALDORF, I	MARYLANI	2060	2.			
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State of Maryland / Department of Health and Mental Hygien [ ] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month OCTOBER 26,2006 JUDY 4:43PMM JOSEPHINE MILLER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIVISTA MEDICAL CENTER CHARLES WALDORF If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Funeral 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 ☐ M 2 🛣 F Director 74 Yrs 232-54-2728 APR.30.1932WEST VIRGINIA Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f ehow 10d. Inside City Limits 1 ☐ Yes 2 No Directo MARYLAND CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or iteme 23a or the Medical Examiner must be 7 2004 WINGATE COURT

1. Marital Status

12. Was Decedent Ever in U.S. Armed Forces? Funeral 20602 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: þ 1 ☐ Yes 2 🔀 No Specify WHITE 3€Widowed 4 Divorced Specify: natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental ပ LENWOOD ALGER AMANDA FRANKLIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20747 f Health MARY JANE LINKINS-DAUGHTER 1644 ADDISON ROAD.S., DISTRICT HEIGHTS, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) FORT LINCOLN CEM. 11-01-06 BRENTWOOD, MARYLAND 21. Signature of Funeral Service Licensee 72. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** yo car /Medical Due to (or as a consequence of) obstructive lung disease Examiner ch romic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated experts. Due to (or as a consequence of) Examiner The faw requires that the death certificate be executed attending physicien and for use as the buriaf-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 3 Probably 4 Tonknown Completed 1 ☐ Yes 2 ☐ No. 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1□ Yes 2⊡No : After this certifical funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 21 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. I Director: # 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide or A To the Hospital of within 24 hours at To the Funeral D pellij 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifiet 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

Maryland 21215-0036

Baltimore,

Box 68760,

P.O. P

Division of Vital Records,

m.d

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAYANTHAN .

32. Registrar's Signature

NIRMALADEVI

31. Date filed (Month, Day, Year)

D 4573

3328

oldwashing ton Rd

20602

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			For State Registrar	State of M		epartment of Certificate o			giene 00 (	35807
-	Physic	ian	1. Decedent's Name (First, Middle, La	•				2. Date of De. Month	ath Day Ye	3. Time of Death
	/Medi Examir		ZELMA NADI 4a. Facility Name (If not institution, give		NDALL	4b. City, Town	n, or Location of De	OCT eath	24 200 4c. County of (	
	LAAIIIII	)   C	CHESAPEAKE F			ARNOL	-D		ANNE	ARUNDEL
÷	Funeral Director			Sex 7. Ag	e (In yrs. last birth	day) If Under 1 Ye.  Months Day	ar If Under 24 H ys Hours M	8. Date of Birt (Month, Da 09/01/1	y, Year)	Birthplace (State or Foreign Country)
	aryland ehow		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Ba-fet	Director	MD ANNE ARU	NDEL	GLEN BU	RNIE				1 ☐ Yes 2X No
	with th	Dire	10e. Street and Number			10f. Zip Code	9		10g. Citizen of Wha	t Country?
	me 23	Funerai	222 WICKLON AVE.  11. Marital Status	12. Was Decedent	Ever in U.S.	21061  13. Was Decedent of If Yes, specify C	of Hispanic Origin?		USA 14. Race - /	American Indian,
21215-0036	s 1 end 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I then 12 is marked other than "natural; or items 23a or 28a-1 show other traumatic event, its Medical Exposite must be notified at	b	1 Never Married 2 Married 3 X Widowed 4 Divorced	Armed Forces?  1  Yes 2 If Yes, Give Year or Dates:	No	If Yes, specify C		erto Rican, etc.)	Specify:	White, etc.
15-0	"natur	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		Decedent's Usual Occ Give kind of work doi life. DO NOT use ret	ne during most of v	working	16b. Kind of Busin	ess/Industry
212	within riene.	omp	Elementary/Secondary (0-12)	College (1-4or !	5+)	EMAKER	1100)		OWN HOME	
	be filed ital Hygir of other event, II	Be C	17. Father's Name (First, Middle, Last	)	1,555		18. Mother's N	lame (First, Middle,		
yla	2 should be and Mental is marked (	5	UNKNOWN SHINAULT	T 010			UNKNOW			
Maryland	end 2 sh salth and n 27 is n	9	JOHN JOSEPH ROMM			Mailing Address (Stre			·	
ore,	of Health of Health fitem 27		20a. Method of Disposition			O CROSS CE Disposition (Name of crematory or other p		Date Date	20c. Location - City	
altimore,	0 0		1 ☐ Burial 2 🗷 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Con		1277	AKE CREMA	1	27/2006	STEVENSVI	LLE, MD
Balt	permit. Pag Department Important: f eny injury o		21. Signature of Juneral Service Lice		Lu.				AM FUNERA MD 21619	L HOME , P.A.
Andrew A	Physician /Medical Examiner	iner	23a. Part1. Enter the disease, or com schools, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. CERE  Due to (or as	ne.	SCLLLAR ):			1031,	Approximate Interval Between Onset and Death
8760,	icate be executed physicien and s the burial-transit	edicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of	):				
P.O. Box 6	The law requires that the death certificate be executed tie has been signed by the ettending physicien and hage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 A No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 Ectopic pregnar 5 Other (specify)			23d. Date of Month	delivery Day Year
	w requires that been signed b should be det:	þ	Part II. Other significant conditions	contributing to death b	ut not resulting in t	he underlying cause	given in Part I.		obacco use contribul	te to the cause of death?  Probably 4 Cunknown
of Vital Records,	sician: The law re certilicate has bee irector, page 2 sho	Completed						24a. Was autop	sy prior med? deat	e autopsy findings available to completion of cause of h?
/ita	ertifica actor. p	BeC	25. Was case referred to medical examiner?					eath Check only or		103 20110
5	this bia	2	1 Yes 2 No  27. Manner of Death	Hospital: 1 Inpatie		atient 3 DOA			ence 6 Other (S	Specify)
Division	Jing After fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be			M 1	☐Yes 2☐No		ow injury occurred	
Div	in Diffe		4 Homicide determined	building, et	c. (Specify)	n, street, factory, office		City or Ton	n, State)	r Rural Route Number,
	e Hospital 24 hours e Funeral letely filled	edical	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example 1	nysician: To the best niner: On the basis of and manner sta	examination and/	death occurred at the or investigation, in my	time, date and pla y opinion, death oc	ice, and due to the c curred at the time, o	ause(s) and manne date and place, and	r as stated. due to the cause(s)
1	To the within 2 To the comple	Me	29b. Signature and title of certifier	MD			7531		29d. Date signed (M Dc T 24	
300	5		30. Name and address of per on who	completed cause of d	eath (Item 23a) (T					
12	1		30. Name and address of per in who	6601 Veta	Kins Hw	7 Suite	204,1	Lillersvie	de Mil	21108
K	Sta Registr		31. Date filed (Month Day, Year)	006 32. registra	ar's Signatura	Coerle				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Amend #27,28a-f, State of Maryland / Department of Health and Mental Hygiene State Amend #27,28a-f, g803, 1/19/0 Certificate of Death

Reg. No. Reg. No. 2 A A S

**Physicia** /Medica Examine **Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neture!", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be netitified at 90cg.

Baltimore, Maryland 21215-0036

**Physician** /Medical

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.

To the Funerel Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director. page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	- negistrar							1109.110.7		-0000
	1. Decedent's Name (First, Middle, Last)  Donna L. Koo	ns					2. Date of D Month	Day	200(	3. Time of Death
!	4a. Facility Name (If not institution, give st	reet and number)		4b. City,	Town, or	Location of De		4c. (	County of Death	1 1 201
	Prince George	540500	tal Cen	ter	Ch	evert	4	F	26	
	5. Social Security Number 6 Sex	7. Age	(In yrs. last birth	day) If Under Months	1 Year Days	If Under 241 Hours N		Day, Year)	Co	nplace (State or Foreign untry) MD
	Usual Residence of Decedent		10a Cibr Tour	as I continu						10d. Inside City Limits
.	10a. State 10b. County  MD St. Mary	_	10c. City, Town		Doze	.1.				1 TYes 2 No
	,	/ S	LE	xington		K				
	10e. Street and Number			10f. Zip				10g. Citiz	en of What Co	untry?
	45887 Bob's Co					653			USA	
	1 Never Married 2 Married	<ol> <li>Was Decedent Every Armed Forces?</li> <li>1 ☐ Yes 2 ☑ Note If Yes, Give</li> </ol>	ì	13. Was Deced		spanic Origin? n, Mexican, Pe Specify:	(Specify Yes or Nuerto Rican, etc.)		4. Race - Amer Black, White Specify: Wh	e, etc.
	3 Midowed 4 □ Divorced	Year or Dates:							opeony. Wil	
	15. Decedent's Educ (Specify only highest grade		(	Decedent's Usua Give kind of wo	rk done a	furing most of	working	16b. Kin	d of Business/I	ndustry
	Elementary/Secondary (0-12)	College (1-4or 5+	)	Secre				US	Govern	ment
	17. Father's Name (First, Middle, Last) Frank Ripple						Name (First, Middl .icent We			
	19a. Informant's Name/Relationship (Type Philip Koons	Rural Route Num								
J	20a. Method of Disposition	son		Disposition (Nar		1	Date	-	ation - City or	
	1 XBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Cedar I	, crematory or o	ther place	1	/03/2006			
	21. Signature of Funeral Service Licenses	9	,000.00	22. Name an	od Addres	is of Facility Coad St	Grove-Bo Waynes	werso: boro,	x Funer PA 172	al Home, In 68
	23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused t	he death. Do no	ot enter the mod	de of dying	g, such as care	diac or respiratory	arrest,		Approximate Interval Between
	Immediate Cause (Final					. 4 11 .	- (10	000	,	Onset and Death
	disease or condition resulting in death)	Due to (or as a	consequence of	Y OLC V U	LNIC	UHE	MOVI	uge		
		HUDE	onsequence of	sive (	1	215				
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to to as a	consequence of	):						
	that initiated events									
	resulting in death) Last	Due to (or as a	consequence of	):				~		
	d.			<u> </u>			111	/	KAMPER	
	IF FEMALE:						111	BY METICAL E		
	23b. Was decedent pregnant 23	lc. If yes, outcome of 1 ☐ Live birth 2		3 ☐Ectopic pr	regnancy		COVED	B/ 4.	3d. Date of deli	*
	in the past 12 menths? 1 ☐ Yes 2 ☐ No	4000		E [ ] OIL /			-ATION IPPRO		Month	Day Year
- 1	Part II. Other significant conditions cont	ributing to death but	not resulting in	the underlying c	ause give	on in Part CER	23e. Did	tobacco us	e contribute to	the cause of death?
•	1  Yes 2  Yo 9  Unknown  Part II. Dther significant conditions cont		•				_ 1□		/	obably 4 □Unknown
							24a. Wa	s an opsy formed?	24b. Were au prior to d death?	topsy findings available ompletion of cause of
	OF Was assessed to a first						1 ☐ Yes	2 No	1 🗆 Yes	2□ No
	25. Was case referred to medical examiner?	ospital:			Othe	20	Death (Check only			
	1 Yes 2 No 1 No 27. Manner of Death	1 Ainpatien			28c. Injury	at Nursin	g Home 5 Res			erry)
	1 Statural 5 Pending investigation	28a. Date of Injury (Month, Day 10/26/2006)		OWIL AM	Work	(?	subject	fell		
Total Oct III oct III	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injurbuilding, etc.	y - At home, farr (Specify)	m, street, factory	y, office		28f. Location City or To	(Street and own, State)  Park.	<sup>Nymber of Ru</sup> 45887 Bo <b>MD</b>	ob's Court
	29a. Certifier 1 Certifying Physical Examin	ician: To the best of	my knowledge,	death occurred	at the tim	ne, date and pl	ace, and due to th	e cause(s) a	and manner as	stated.
í	(Check only 2 Medical Examin	er: Un the basis of e	examination and	or investigation	i, in my of	pinion, death o	ccurred at the time	e, date and p	piace, and due	to the cause(s)

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

HOSPITOU DR

ORIGINAL

3001

Cheverly MD

Inc.

Registrar

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ler man

31. Date filed (Month, Day, Year)

		·	1 - For State Registrer	State of Maryl		artment rtificate			nd Me		gienez (	006	35809
	Physici /Medio		1. Decedent's Name (First, Middle, Last	L. K	Elly	Ý				2. Date of Dea	ath Day	2006	3. Time of Death 11:45p M
K	Examir		4a. Facility Name (If not institution, give Winter Growth Howa	rd Center	/	4b. City, 1 Colui	mbia	Location of			How		
:	Funeral Director		5. Social Security Number 6. Se 578–36–1858	x	vrs. last birthday)		Days		Min.	8. Date of Birt (Month, Da) Feb 16:	1926	Coun	lace (State or Foreign try) ington, D.C
	the Maryland 28a-f ehow	Director	10a. State 10b. County MD Howard 10e. Street and Number		City, Town or Lo	10f. Zip	Code				10g Citizon	of What Coun	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with	J Dir	5460 Ruth Keeton W	ay		210					USA	or writat Cour	uy:
920	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other then "naturel", or items 23a or 28a-f ehow event, the Medical Examinar must be notified at	by Funeral	11. Marital Status t ☐ Never Married 2 ☐ Married  \$\times_\times	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedif Yes, spec		spanic Origin, Mexican, I	n? (Spec Puerto R	offy Yes or No- lican, etc.)		Race - Americ Black, White, Boothy White	etc.
Maryland 21215-0036	within 72 hor ene. then "nature the wedited it	Completed	15. Decedent's Edu (Specify only highest grad		(Give	DO NOT us	k done d	lurina most d	of working	g	16b. Kind o	f Business/Ind	dustry
land 2		To Be Co	17. Father's Name (First, Middle, Last) (unk)	White	00010					(First, Middle,	Maiden Sum		<u>-</u>
Baltimore, Mary	of Hearlitem		19a. Informant's Name/Relationship (T)  Jean E. Maase / POA  20a. Method of Disposition  1 □ Burial 2 □ □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	20 Removal from State		Rounds	tree ne of ther place	Lane	Colu		MD 210 20c. Locatio		wn, State
Baltii	permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Licens  Burel L	7 011	Ĝ	2. Name and OING	Addres Home	s of Facility	ation	n Servi	ce P	.O. Box	
8760,	bhyseign en executed for use as the burial-transit	icai Examiner	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conduction)  Due to (or as a conduction)  Due to (or as a conduction)	Faceguente of):  Was sequence ol):	ilu	re						Approximate Interval Between Onset and Death
P.O. Box 68	D o D	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past t2 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	etal death 3	□Ectopic pre						Date of delive Month	ry Day Year
	law requires that the es been signed by th 2 should be detache	by	Part II, Ather significant conditions	ntributing to death but not	resulting in the u	MO	use give	in in Part I.	my	23e. Did to	/		e cause of death?
Il Records,	The ete h page	Completed	Atrial F	ibrilli	thri	45,	,			24a. Was autop perfor 1 Yes	sy med2	b. Were autop prior to con death? 1 \( \text{Yes}	osy findings available inpletion of cause of
Vita	Physician: Th r this certificete ral director, pag	Be C	25. Was case referred to medical examiner?	Hospital:			Othe			Check only o			
Division of Vital	Jing After fune	atlon; To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year	2 ER/Outpatier 28b. Time o Injury		Bc. Injury Work		28	e 5 ☐ Resid			"
Divis	5 £ £ €	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, st ecify)	reet, factory,	, office		28	BI. Location (S City or Tow		mber or Rura	l Route Number.
	To the Hospital within 24 hours a To the Funerel Completely filled	Medical	(Check only 2 Medical Exami	sicien: To the best of my ner: On the basis of exam and manner stated.	knowledge, deat nination and/or in	vestigation,	in my op	inion, death	place, ar occurred	d at the time, o	late and plac	e, and due to	the cause(s)
	or with or or or or or or or or or or or or or		29b. Signature and title of certifier	chhma	an, n	10	D-	501	84	Ż _	Oct 7	ined (Month, L	2006
<u>1)</u>	ad		30. Name and address of person who co	7 RAL	IKH,	Print)	TIV	818 E1	Kric	JOE,	MD	71073	74301
	Sta Registr		31. Date filed (Month, Day, Year)	32. Redistrar's Si	ignature	barde	,			ŧ			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 2006 25, Clifford Paul October 8:00 рм /Medical 4h. City. Town, or Location of Death 4c County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Avalon Home Rockville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**⊠**M 2□ F Yrs. Director 89 1917 Tennessee 292-26-1537 Usual Residence of Decedent with the Maryland 10a. State 10b. Count 10c. City. Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Example must be notified at 1 Yes 2 No Director Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 13327 Foxhall Drive USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status tiled within 72 hours after I Hygiene. other than "natural", or Ite 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WWII or l 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: SpecifWhite þ 3 → Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Engineer Military Technology permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, Important: if item 27 le marked othe any in Jug De Other territories. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charlie Lard Clura Hunt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas W. Lard/ Nephew 4059 Cavens Road, Savanah, Tennessee 38372 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition October 30 1 ₺ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemeterv 2006 Silver Spring, Maryland 21. Signature of Funeral Service Licenses Francis Address Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 Carros 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heart Failure 2 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Diju to for as a consequence off-Examiner Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Dav 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2x ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Dementia peeu 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificete 2 No 1 Yes 2 🙀 No 1 Yes neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other  $_{4}$  Nursing Home  $_{5}$  Residence  $_{6}$  Other (Specify Assisted Hospital: Certification: To 1 ☐ Yes 2 ₩ No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Living 1 🙀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aff To the Funeral DI 1E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D009317 October 26, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2333 S. Nash Street, Arlington, Virginia 22202 Robert Byrne, 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 27 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 23 2006 730 Priscilla Lightfoot October Valerie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisbury Wicomico Peninsula Kegional Medical Center If Under 1 Year If Under 8. Date of Birth (Month, Day, Year) Nov.1 1930 9. Birthplace (State or Foreign Social Security Number **Funeral** Days 1 □ M 2 75 215-26-6081 Maryland Director Usual Residence of Decedent with the Maryland 10c City Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 XYes 2 No Director Wicomico Salisbury Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code the Medical Examiner must be 21801 U.S.A Funeral 214 Delaware Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: \$ 3XWidowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic None permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If item 27 is marked other ti any Injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Stanley Pinkett Sr. Roxie Parson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 214 Delaware Ave. Salisbury, Md. 21801 Eugenie P.Shield (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springhill Mem Garden Hebron, Md. 22. Name and Address of Facility Stewart Funeral Home 821 West Rd.Salisbury, Md.21801 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear dailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) U Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed burial-tran Due to (or as a consequence of) physician Physician/Medical IE FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 ☐ Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s performed 2 No Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 📈 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral filled in the funeral filled in by the funeral filled in the funeral fil death. 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated To the I within 2.

2 max

-26-6081

State Registrar 29b. Signature and title of certifier

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

100 E. Carroll

2006

OCT 26

bury, Md

SAlis

54.

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

			For State Registrar	State of Ma	aryland /	Departmo Certific			and Me		iene <sub>eg. N</sub> 2 (	006	35812
*	Dhusisi		1. Decedent's Name (First, Middle, L	ast)					2.	Date of Dear Month	th Day	Year	3. Time of Death
	Physicia /Medic		Ralph C. I							ctober	18	2006	7:35 P M
	Examin	er	4a. Facility Name (If not institution, g			4b. C	ity, Town, or					unty of Death	
		150	12015 Hicko		(In yrs. last b	inthday) If Un	Ft.	Washi If Under 2	ngton 24 Hrs. 8	Date of Birth			George's
	Funeral Director		244-52-9694	1 □XM 2□F	70	Yrs. Mont		Hours	Min.	(Month, Day,	Year)		olace (State or Foreign htry) h Carolina
	D		Usual Residence of Decedent						1.11	00, 13	, ,,,		
	arylar show	2	10a. State 10b. County		10c. City, Tov	wn or Location							10d. Inside City Limits 1   Yes 2  No
	Ne M.	Director	Maryland Prince 10e. Street and Number	George's		404	Ft.	Wash	ingto		On Citizon	of What Cou	
	with la or i			. Design		101.	ZIP C004	20744		'		nited	•
	hours after death with the Maryland tural, or items 23a or 28e-f show at Examinational be notilied at	Funeral	12015 Hickory	12. Was Decedent 8	Ever in U.S.	13. Was De	ecedent of H			y Yes or No- an, etc.)	14.	Race - Ameri	can Indian,
٥	or ites		1 Never Married 2 Marned	Armed Forces?  1 □XYes 2□N  If Yes, Give	io		specify Cuba s 2 <b>√</b> □ No	an, Mexican, Specify:	, Puerto Ric	an, etc.)		Black, White,	
2-003p	ural',	d by	3 Widowed 4 Divorced	Year or Dates:		10.10	s 24-110	зреспу.					lack
2	"natı	Completed	15. Decedent's (Specify only highest g		168	a. Decedent's U (Give kind of life. DO NO	work done	during most	of working		16b. Kind o	of Business/In	dustry
7	within iene.	dmc	Elementary/Secondary (0-12)	College (1-4or 5	+)		Chemis	,				Gover	nmont
מ ם	Hyg The	Be Co	17. Father's Name (First, Middle, Las				onemits		r's Name (F	irst, Middle, i	Maiden Sur		Imient
yland		To B	Royal C	lemmon Hodg	e				Ino	nia Sa	phron	ia Jon	es
Mary	s 1 and 2 should I f Health and Meni item 27 is marked other traumatics		19a. Informant's Name/Relationship			b. Mailing Addi						wn, State, Zij	Code)
	and 2 ealth n 27 in		Dorothy C. Hoo	ige/Wife		2015 H		Dr.,				20744	
Baltimore,	ges 1 a t of Hea if item or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from State	cemet	ol Disposition ( ery, crematory	or other plac		Date		20c. Locati	ion - City or To	own, State
E	t. Partmen		4 □ Donation 5 □ Other (Spec	cify)	Linco	1n Memo	-					itland	<del></del>
g	permit. Pages Depertment of I Important: If its any injury or o		21. Signatura of Funeral Service Lic	Stara t	711		and Addre					1 Home, DC 2	
			23a, Part1. Enter the disease, or co	mplications that caused	the death. Do							, DC 2	Approximate
	Physician		shock, or heart lailure. List on Immediate Cause (Finat disease or condition			n.							Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	a. Park Due to (or as a		s Disea	se						
	Examiner		Conventially list conditions	Ь									
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	e ol):							
	ecute and trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	2.0000000000	2 01):							
8760,	ate be executed thysicien end the burial-transit	calE		Due to (or as a	a consequence	5 017.							
/89	certificate be executed nding physicien end use as the burial-transit	73		d									
Rox	Jeath certifica ettending ph d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d.	Date of deliv	ery
	0 0 2	lcla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at		th 3 ⊟Ectopi	c pregnancy (specify)	<i></i>				Month	Day Year
J.	that the dened by the detached	hys	9 ☐ Unknown	9Ll Unknown									
	8 6 8	by	Part II. Other significant conditions	contributing to death bu	ut not resulting	in the underlying	ng cause giv	en in Part I.					he cause of death?
ecords,	w require been si	Completed			<u> </u>		-			1 1 1	es 2□N	0 3 PIO	oably 4 Unknown
€C	e law has b	nple								24a. Was a autops perfor	Sy	4b. Were auto prior to co death?	opsy lindings available empletion of cause of
Vital R	sician: The law certificate has l rector, page 2 s									1 Yes	2 X No		2 No
	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🏋 No	Hospital:	int 2 ER/C	Autostiont 3	DOA Oth			Check only on		Other (Special	6.1
ö	g Phys er this eral di	n: To	27. Manner of Death	28a. Date of Injur	ry 28b.	Time of	28c. Injur Wor			d. Describe h			<b>y</b> /
Division	Attending in death.	Certification:	1 XNatural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Day	y Teal)	Injury M		Yes 2 1	No				
<u> </u>	r Atte	t t t t	3 Suicide 6 Could not 4 Homicide determine			larm, street, fac	ctory, office		281	Location (Si		umber or Rur	al Route Number,
	ours after ours after here! Dir filled in I												
	Hos Fur 18ly	edical		Physician: To the best of aminer: On the basis of	examination a								
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	and manner sta	aldu.		29c. Licens	e number		2	9d. Date si	gned (Month,	Day, Year)
1	+ 3 + ŏ		<b>→</b> //3	21/ Agree 6	<del>4</del>			D4628	35				23, 2006
0	(5)		30. Name and address of person wh	io completed cause of d	eath (Item 23a	) (Type, Print)							-
<i>ب</i>			Paul Bone	M.D. 109	05 Ft.	Washin	gton F	Rd., #	206	Ft. Wa	sh.,	MD 20	744
	Sta		31. Date filed (Month, Day, Year)	22. Registra	ar's Signature	ha. Hi		-			•		
6	Registi	ar	OCT 2 4 200	Dedu	N. F	The same of the sa							

			1 - For State Registrar		State of	f Maryla	ind / Dep	artmen rtificat			ınd M	lental H	ygiene Reg. No	$\leq U$	06	35813
	Physic		1. Decedent's Name (First, Mic Stephanie		wis							2. Date of to Month OCt.	Death Da	y 2.0	) 0 6	3. Time of Death 11:55PM
	/Medi Examii		4a. Facility Name (If not institut Saint Thoma	ion, give s S MC	ore N	ursin	ome 1g			Location of Vill			40		y of Death	11.551
ľ	Funeral Director		5. Social Security Number 579-80-8642	6. Sex	M 2 <b>⊠</b> F		s. last birthday)	If Under Months		If Under 2 Hours	24 Hrs. Min.	8. Date of E (Month, I OCt.	Birth Day, Year,	54	Cour	place (State or Foreign http) h.D.C.
	e Maryland	ctor	Usual Residence of Decedent  10a. State D. C.	ty			City, Town or Lo								1	10d. Inside City Limits 1   Yes 2   No
	th with th	Funeral Director	1322 Veg and Number St	. N	.E.			10f. Zip 20	018					tizen of	What Cour A .	ntry?
9036	be filed within 72 hours after death with the Maryland tall Hygiene. dother than "natural", or Items 23a or 28a-1 show event, tra Medical Exartinar must be routified at	þ	11. Marital Status  1 ☐ Never Married 2 ☐ M. 3 ☐ Widowed 4 🎇 Divorce	arned	I2. Was Dece Armed For 1 ☐ Yes If Yes, Giv Year or Da	rces? 2 <del>[X]</del> No e		Was Deced I Yes, spec		spanic Orig n, Mexican, Specify:	in? (Spe , Puerto	ecify Yes or N Rican, etc.)	No-	14. Rad Bla Specif	ce - Americ ck, White, ack y:	ean Indian, etc.
Baltimore, Maryland 21215-0036	c _ @	Completed	15. Deced (Specify only high Elementary/Secondary (0-12 8th	est grade	cation completed) College (1	-4or 5+)	16a. Dece (Give life. Hous	kind of wo. DO NOT us	rk done d se retired)	ution uring most	of worki	ng			te Co	dustry Ompany
yland	2 should be filed withli and Mental Hygiene. is marked other than aumatic event, the M	To Be	17 Eather's Name (First Middle Herbert Lew							Det	orı		ICK			
, Mar	as 1 and 2 should of Health and Men item 27 is marker other traumatic		19a. Informant's Name/Relation DeLoris Le	wiship (Typ	-Moth€					nd Number St	or Rura N	.E. W	ber, City o lash.	or Town,	State, Zip	20018
timore	permit. Pages 1 Department of Hi Important: If iten eny injury or oth		20a. Method of Disposition 1 ♥ Burial 2 □ Cremation 1 4 □ Donation 5 □ Other	(Specify)		State Mo	Place of Dispo cometary, cres	Tive	ther place Ce		ct.		Was	sh.,		
Bal	permit Depar Impor eny in		21. Signature of Funeral Service	- VR	obin	sm								3 6	)1 5th S	St.N.W.
4	death certificate be executed  Water leading physician and for use as the burial-transit death and for use as the burial-transit death and the purity of the	ledical Examiner	23a. Pand. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)  Suentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a a b	Huma  Due to (c	ach line.	nunode:									Approximate Interval Between Onset and Death Years
P.O. Box 6	that the death certifica and by the attending ph detached for use as the	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23		nth 2 ☐ Fei ant at time of	tal death 3	Ectopic pro						23d. Dai Mo	te of delive	ry Day Year
	og og	by	Part II. Other significant condi Respirator	ons control	ributing to de ailur	ath but not re	sulting in the ur	nderlying ca	use giver	n in Part I.						e cause of death?
	The law ate has b page 2 sl	Completed	Sepsis Syn		me							perl	s an opsy formed? 2 2 No			osy findings available npletion of cause of 2 No
		o Be	25. Was case referred to medic examiner?  1 ☐ Yes 2 ☒No		ospital:	patient 2	☐ ER/Outpatien	2 00	Other			(Check only				
	Attending Physic death.  octor: After this by the funeral dispets of the funeral dispets the funeral dispets the funeral dispets of the f		27. Manner of Death 1 Natural 5 Pend	ing tigation	28a. Date of		28b. Time of Injury		Bc. Injury	4 (A INUIS	2	ne 5 Res 8d. Describe				)
Division	o ire	Certification:	3 ☐ Suicide 6 ☐ Could	not be mined	28e. Place o buildin	of Injury - At I g, etc. (Spec	home, farm, stre	et, factory,	office		2	8f. Location City or To	(Street and State)	d Numb	er or Rural	Route Number,
	he Hospital n 24 hours a he Funeral t pletely filled	edicai	29a. Certifier 1 Certify (Check only one) 1 Medica	ing Physi I Examin	cian: To the l er: On the ba: and mann	sis of examin	nowledge, death lation and/or inv	occurred a estigation,	it the (ime in my opi	e, date and nion, death	piace, a occurre	nd due to the d at the time	cause(s) date and	and ma place, a	nner as sta and due to	ated. the cause(s)
	To the Younglest complete	×	29b. Signalure and title of certif	0	and	Wes	m		D185		_	1	0ct	20	(Month, D	)6
_	Gyc		30. Name and address of perso Paul A. De	vho con	npleted cause	of death (Ite	т 23a) (Туре, I 4203	Que	ensb	ury	Rđ.	Hyat	tsvi	11e	,Md	20781
47	Sta Registr	te	OCT 23 2006	ban	32. Re	pistrar's 9 m	a limited									

		For State of Maryland Registrer	/ Department of Health and i Certificate of Death		ene 3. No. 2006	3581
Physic /Medi		1. Decedent's Name (First, Middle, Last)  SYDNEY A LAZAR	•	2. Date of Death Month	Day Year <b>20 206</b>	3. Time of Death 2 2 5 P M
Examir		4a. Facility Name (If not institution, give street and number)  CHARES COUNTY NURSITH AND		)	4c. County of Death	COUNTY
Funeral Director		5. Social Security Number 6. Sex 7. Age ( <i>In yrs. las</i> 577–44–9129 1 □ M 2XXF 72  Usual Residence of Decedent	t birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth Month Day, Aug. 23,	9. Birthpla Countr Washii	ngton, DC
with the Maryland a or 28a-f ehow	ctor	10a. State 10b. County 10c. City, 1	Town or Location		100	d. Inside City Limit
th with th	al Director	10e. Street and Number 6909 Dudley Avenue	10f. Zip Code 20745	10	g. Citizen of What Countr USA	y?
72 hours atter death with the Maryland natural; or Itema 23a or 28a-f ehow pleut Examinar man be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ★★ Married 2 □ Married  3 ★★ Married 2 □ Married  3 ★★ Married 2 □ Married  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ★★ Or Dates:	13. Was Decedent of Hispanic Origin? (Sr If Yes, specify Cuban, Mexican, Puerto 1  Yes 2XXNo Specify:	pecify Yes or No- Dican, etc.)	14. Race - America Black, White, et Specify: Whit	c.
within piene.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12)  College (1-4or 5+)	Decedent's Usual Occupation     (Give kind of work done during most of work life. DO NOT use retired)     Childcare	king 16	Bb. Kind of Business/Indu	stry
s 1 and 2 should be tiled f Health and Mental Hygis item 27 is marked other other traumatic event, II	To Be C	17. Father's Name (First, Middle, Last)  James Lazar		ne (First, Middle, Ma et Cameron	uden Sumame)	
		19a. Informant's Name/Relationship (Type, Print) Tammy Baird / Daughter	19b. Mailing Address (Street and Number or Ru 6909 Dudley Avenue Oxor.	ral Route Number, ( Hill, Mary		Code)
Page nent o ant: If ury or		XX Burial 2 Cremation 3 Removal from State	etery, crematory or other place) bia Gardens Cemetery 10/27	7/2006 A	oc. Location - City or Tow rlington, Virg	inia
permit. Pag Department Important: I any injury o		21. Signatur Funeral Service Lice/see	22. Name and Address of Facility Get 6160 Oxon Hill Road O	xon Hill, M	aryland 2074	
Physician and /Medical Examiner bhysician and sthe privial-transit	al Examiner	resulting in death)	DIOPULMO. HAZY AND COOP):  US CELL CAME coop):	LREST		nterval Batween Onset and Death
death certif e attending ed tor use as	Physician/Medical	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ath 3 Ectopic pregnancy		23d. Date of delivery Month D	ay Year
w requires that the been signed by th should be detache	by	Part II. Other significant conditions contributing to death but not resultine HYPERCALCEM	ng in the underlying cause given in Part I.		cco use contribute to the	
The law ate has b page 2 sl	Completed			24a. Was an autopsy performe	24b. Were autops prior to comp death?  No 1 Yes 2	y findings available letion of cause of
Physician: r this certifica ral director.	To Be	25. Was case referred to medical examiner?  1 □ Yes 2 No  Hospital: 1 □ Inpatient 2 □ ER		h (Check only one)	ce 6 ☐ Other (Specify)	
of the land	Certification: 7	27. Manner of Death  1 Natural  2 Dending  2 Accident  5 Pending  2 Accident  investigation  5 Could not be	b. Time of linjury at Work?  M 1 Yes 2 No	28d. Describe how		
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely tilled in by the fu	al Certif	28e. Place of Injury - At home building, etc. (Specify)  29a. Certifier  Certifying Physicien: To the best of my knowle		City or Town,		
To the Hospital within 24 hours of the Funeral completely tilled	Medical	one) 2 Medical Exeminer: On the basis of examination and manner stated.	and/or investigation, in my opinion, death occur	red at the time, date	and place, and due to th	ne cause(s)
S O O O	4	29b. Signature and title of certifier	29c. License number  D006165	2	Date signed (Month, Da	4
(5)		30. Name and address of person who completed cause of death (Item 23 ATUL KATTAL; 11350 PEM	BOOKE SO, SUITE 3	104, LA	PLATA, M	D, 2060;
Sta Registr		31. Date filed (Month, Day, Year)  OCT 2.4 2006	herte			

			For State	State of Mary		artment of F			ene (	) 6	35815
est.	*		Registrar     Decedent's Name (First, Middle, Last	")		imodio or	Douin	2. Date of Death		V	3. Time of Death
	Physici /Medic		GRACIE L. LEE					OCTOBER	Day 18, 20	Year 006	12:30PM
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death		4c. County		
			PRINCE GEORGES HO 5. Social Security Number 6. Se		rs. last birthday)	CHEVER	LY If Under 24 Hrs.	8 Date of Birth			EORGES lace (State or Foreign
	Funeral Director			M 2□F	70 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, APR. 11,	1936	NORT	H CAROLINA
	pu ,		Usual Residence of Decedent	110	c. City, Town or Lo	1140					
	ehov	or	10a. State 10b. County							10	0d. Inside City Limits  XX Yes 2 □ No
	28a-f	Director	MD PRINCE G	EORGES 1	4ITCHELLV	10f. Zip Code		10	g. Citizen of W	/hat Count	
	death with the Maryland ims 23a or 28a-f ehow r.must be notified at	ID IE	11421 WAESCHE DR	IVE		207	21		UNITED		•
	ams 2	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto		14. Race	e - Amenca k, White, e	an Indian,
20	n 72 hours atter death with the Marylan "natural", or Itams 23s or 28s-f ehow solical Examinar must be notilied at	by Fu	1 ☐ Never Married 2 ☐ Married  \$\mathbb{X} \mathbb{M} \mathbb{W} \middle \mathbb{M} \mathbb{O} \middle \mathbb{M} \mathbb{O} \middle \mathbb{M} \mathbb{O} \middle \mathbb{M} \mathbb{O} \middle \mathbb{M} \mathbb{O} \middle \mathbb{M} \mathbb{O} \middle \mathbb{M} \mathbb{O} \middle \mathbb{M} \mathbb{O} \middle \mathbb{M} \mathbb{O} \middle \middle \mathbb{O} \middle \mathbb{O} \middle \mathbb{O} \middle \mathbb{O} \middle \mathbb{O} \middle \mathbb{O} \middle \mathbb{O} \middle \mid	Armed Forces? 1 □ Yes XX No If Yes, Give		1□Yes XX No	Specify:			BLA	
2-003e	2 hour		15. Decedent's Edi	Year or Dates:	16a. Dece	dent's Usual Occup	ation during most of work	1	6b. Kind of Bu		
2 2 2	within 72 ene. then "nal	plet	(Specify only highest grad		(Give	kind of work done OO NOT use retired	during most of world)	king			
7		Completed		1+	EI	DERLY CA			STATE C		RYLAND
and	a la b	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, M	aiden Sumam	θ)	
5	should ind Men in marke	2	TYLER GRANT  19a. Informant's Name/Relationship (T)	vpe. Print)	19b. Mailir	ng Address (Street		A VIRGIL	City or Town.	State. Zin	Code)
Z Z	nd 2 lith a 27 is		CHRISTOPHER STEP			LIVE OAK		UPPER M			
more,	of Hea of Hea of Hea of Hea of Hear		20a. Method of Disposition  XiX Burial 2 □ Cremation 3 □ I		Ob. Place of Dispo	sition (Name of natory or other place	ce)	Date 2	Oc. Location -	City or To	wn, State
	Pages ment of ant: If It		4 Donation 5 Other (Specify,	V V	VASHINGTO	NATION	AL CEM. 1	0/26/06	SUITI	AND,	MD
Balt	permit. Pag Department Important: eny Injury o		21. Signature of Funeral Service Licens	SHIL	22	Name and Addre MARSHALL 4308 SIIT	S FUNERA	L HOME O	F MARYI	AND,	INC.
			23a. Part 1 Enter the disease, or comp shock, or heart failure. List only of	lications that caused the ne cause on each line.	de th. Do not ent					2071	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Corel	not	ink	and	an .			Onset and Death
	/Medical Examiner		resulting in deathy	Due to (or as a co	nsequence 📆	_	7	,			
		e	Sequentially list conditions, if any, leading to immediate	b. Due to o as a col	nsequence of):	rsec	2				
	outed td ransit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	coro	nan	an	len	Dis	en	e	
Ď,	be execu- icien and burial-trar	Ex	resulting in death) Last	Que to (or as a co	nsequence of):	2	1	11			
g/60	ys he	dlcal		d. Corman	art	m D	ipass G	MITT			
o X		0.3	IF FEMALE:	23c. If yes, outcome of pr	egnancy	U			23d Date	e of delive	rv.
ň	death certi e ettending id for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ※※No	1□Live birth 2□ 4□Pregnant at time		Ectopic pregnancy Other (specify)	(		Mor		Day Year
5	the y th	hys	9 ∐ Unknown	9□ Unknown							
coras, I	w requires thet the de been signed by the e should be detached f	ρ	Part II. Other significant conditions co	ntributing to death but no	t resulting in the u	nderlying cause giv	en in Part I.	23e. Did toba			e cause of death? ably 4 □Unknown
ပ္သ		Completed						24a. Was an autopsy	24b. V	Vere autop	sy findings available
<u> </u>	The cete h	Con						perform 1 ☐ Yes 2	No 1	eath?	2□ No
Vital	Physician: The law this certificete has trail director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		Oth	or	th (Check only one			
5	Phys r this ral dir	To	1 Yes 2 No  27 Manger of Death	28a. Date of Injury	2 ER/Outpatier	t 3LI DOA	4 □ Nursing H	ome 5 Residen			)
0	nding tth. :: Afte e fune	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	ar) Injury	Wor	k? Yes 2 □ No		,,		
DIVISION	r Atter er dea rector by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S		eet, factory, office		28f. Location (Stre City or Town,		er or Rural	Route Number,
5	ital or irs att ral Di										
	To the Hospital or Attending Physician: Within 24 hours after deals To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	sician: To the best of my iner: On the basis of exa and manner stated.	knowledge, death mination and/or in	n occurred at the tirvestigation, in my o	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	ise(s) and mar e and place, a	nner as sta and due to	ited. the cause(s)
		Σ	29b. Signature and title of certifier	0		29c. Licens	1	290	d. Date signed	(Month, D	)ay. Year)
	3		1 Cal	en			03/8	2 /	0/18	8/0	26
_			30. Name and address of person who of JAMES CATEVENIS,	MD	3001 но	SPITAL D	RIVE CHE	EVERLY, MI	20784	<i>(</i> +	
	Sta Registr		31. Date filed (Month, Day, Year)  OCT 2 4 2006	33 Registrar's S	B. Spe	di					

	1 - State Registrar			Ce	ertificate o	Health and M f Death	R	leg. No.	006	358	
		ne (First, Middle, Las	t)				2. Date of Dea Month	th Day	Year	3. Time of D	
cian		ret Tyser					October			2:08	ам
lical	4a. Facility Name (	(If not institution, give	street and number)		4b. City, Town	, or Location of Death		4c. C	ounty of Death		
iner		Georgia Av				Spring			Montgom		
1	5. Social Security I	Number 6. Se	ex 7. Age (i	In yrs. last birthday	/) If Under 1 Ye Months Day	ar If Under 24 Hrs. /s Hours Min.	8. Date of Birth (Month, Day	y, Year)	Cou	place (State or ntry)	
r	578-07-98	889	□M 2 <b>©</b> F	94 Yrs.			Aug. 30	). 19	12  Was	shingtor	1, DC
	Usual Residence of	of Decedent 10b. County	1	Oc. City, Town or	Location					10d. Inside City	Limits
5	Maryland	Montgor	merv	Silver	Spring					1 🗌 Yes	2 🙀 No
Director	10e. Street and Nu				10f. Zip Cod	9		10g. Citize	en of What Cou	intry?	
늅			3	1	20902				USA		
by Funeral	10800		Avenue, #10	er in U.S. 13		of Hispanic Origin? (Sp Juban, Mexican, Puerto	ecify Yes or No-	. 14	4. Race - Amer Black, White		
L.		rried 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give				ricari, etc.)		Specify.Whit		
þ	22	4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐	чо зресну.					
ted	(6-1	15. Decedent's Ed	ducation	(Gi	cedent's Usual Oc	ne during most of work	ang	16b. Kin	d of Business/I	ndustry	
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Completed			2		Secretar	y 18. Mother's Nam				Invest	ments
Be	17. Father's Name	e (First, Middle, Last,	)						, and a		
10		P. M. Lo				Marga eet and Number or Ru	ret Tyse		Town State 7	in Code)	-
		Name/Relationship (				Circle, Bo					
		Horner/ F	riend		Epnron sposition (Name o		Date Ind.		cation - City or		
1	20a. Method of D	isposition 2 Cremation 3 E	☐Removal from State	cemetery, c	rematory or other	place) Octob	er 24,				
	4 Donation	n 5 ☐ Other (Special	fy)	Rock Cre			06	Washi	ington,	DC	
	21. Signature of	Funeral Service Lice	nsee		22. Name and Ad Francis	T Colling	Funera	1 Hon	ne Inc.	MD 1	0003
SOC SOC SOC SOC SOC SOC SOC SOC SOC SOC	Ma	emes 5	Ooday		500 Univ	ersity Blv	d, W, S	11vei	Sprin	Approximate	9
	23a. Part1. Er	r the disease, or con eart failure. List only	nplications that cau ed to one cause on each line	he death. Do not	enter the mode of	dying, such as cardiac	or respiratory a			Onset and D	
	Immediate Caus disease or condi	ition	a Congestiv	re Heart	Failure					10 Yea	rs
il r	resulting in death	h)	Due to (or as a	consequence of):							
	Cognontially list	conditions,	b. — Due to lor oc o								
<u>=</u>				concoguence of).							
	cause. Enter Un	nderlying	Due to jor as a	consequence of):							
kamir	cause. Enter Un Cause (Disease that initiated eve	or injury	С.								
i Examiner	cause. Enter Un Cause (Disease that initiated eve resulting in death	or injury	С.	consequence of):							
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		For State	State of Maryla	nd / Dep	artme		ealth and l	_		<sup>9</sup> nn	6 (	358	17
		1. Decedent's Name (First, Middle, Last,	1			10 01 1	Journ	2. Date of		0.		3. Time o	of Death
Physic	ian	Tho Chieu Lee						Month	D	,	ear		рм
/Medi		4a. Facility Name (If not institution, give	street and number)		4b Cit	v Town or	Location of Deatl	Octol	1	c. County of		3:24	
Exami	ner				70. 01			•					
-\$** 4.80	2/4	Washington Advent: 5. Social Security Number 6. Security Number	ist Hospital	s. last birthday	tf Und	Takoi er 1 Year	ma Park If Under 24 Hrs.	8 Date of	Birth			omery	or Foreign
Funeral Director	1		≹M 2□F	82 Yrs.	Month		Hours Min.	8. Date of (Month, May 12	Day, Year	24	Countr	Nam	or r or organ
3.		Usuat Residence of Decedent						1107 21	,				
land		10a. State 10b. County	10c. 0	City, Town or L	ocation						100	d. Inside C	ity Limits
Mary F sh	ŏ	Maryland Montgome	rv	Montg	omer	v Vil	lage					1 🗌 Yes	2 <b>_¥</b> No
the 28s	ec	10e. Street and Number	-13			Zip Code			10g. C	itizen of Wh	at Countr	y?	
with no state of	0	10020 Battleridge	e Place			20886				US	A		
ING 21215-0036  be filed within 72 hours after death with the Maryland hall Hygjene. d other then "naturel", or Itema 23a or 28a-f show event. I'm Modical Examinat must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Dec	edent of Hi	ispanic Origin? (S In, Mexican, Puerl	pecify Yes or	No-	14. Race -	America	n Indian,	
ler d	l H	1 Never Married 2 Married	Armed Forces?		If Yes, sp	ecify Cuba	n, Mexican, Puert	o Rican, etc.)		Black,	White, et		
0036 hours after turef, or its	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 🔀 No	Specify:			Specify:	As	ian	
5-0036 72 hours aft naturef, or	Completed	15. Decedent's Edu		16a. Dece	dent's Us	ual Occupa	ation		16b.	Kind of Busii	ness/Indu	ıstry	
In 72	ple	(Specify only highest grad		(Give	kind of v DO NOT	vork done d use retired	during most of wor l)	rking					
2121; ad within 7 giene. er then "	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Inform	ant/1	US Amba	assador to	Viet Na	n	Gove	rnmeı	nt	
Hyg Hyg		17. Father's Name (First, Middle, Last)		1			18. Mother's Nar	ne (First, Midd	lle, Maide	n Sumame)			
Maryland d 2 should be file th and Mental Hy t7 is marked oth traumatic event	To Be	Chu Ngien Ly					Chan	Bau Tra	an				
re, Maryland 2121; s 1 and 2 should be filed within : Health and Mental Hygiene. Item 27 is marked other than "I	1	19a, Informant's Name/Relationship (T)	rpe, Print)	19b. Mail	ng Addre	ss (Street a	and Number or Ru	ırai Route Nur	nber, City	or Town, St	ate, Zip C	Code) a	1886
Ma Itha 27 is		Yin Lee/ Wife					tleridge						
ore, M as 1 and 2 of Health litem 27	1.0	20a. Method of Disposition	20b.	Place of Disp	osition (A	ame of		Date	7	Location - Ci			C, 11
0 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ F		cemetery, cre	-		Octo	ber 29					_
Baltimore, permit. Pages 1 a Department of Her important: If item any injury or othe		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens		rklawn M			, 4	006		kvill		aryla	ind
		21. Signature of Funeral Service Licens		F	ranc.	is J.	s collins	Funera	al Ho	me In	c.	wn a	0001
40144		23a. Part 1. Enter the disease, or compleshock, or hart failure. List only o	roles.				sity Blv			r spr	-	Approxima	
Physician (Be executed Associated	cal Examiner	disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):	eli el	se Stry	reples	eelu	eni				
687 ificate g physias the			d										
O. BOX ne death cert the attendin	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	⊒Ectopic ⊒ Other (	pregnancy (specify)			-	23d. Date of Month			Year
that the od by	된	Part II. Other significant conditions co.	ntributing to death but not re	esulting in the t	underlying	cause give	en in Part I.	23e. Di	d tobacco	use contrib	ute to the	cause of	death?
OrdS, requires sen sign	Q P							1(	] Yes	2X No 3	☐ Probal	bly 4 🗆	Unknown
COTGS, P w requires that been signed to should be det	Completed by							04- 14		045 144		6	atabta
II Rec	I d							24a. W	topsy	pric	or to compath?	sy findings pletion of	cause of
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of Vital Records, Physician: The law requires to this certificate has been signer and director, page 2 should be to	Be	25. Was case referred to medical examiner?	trooper 57			1 000	26. Place of Dea	ath Check on	one)				
of others	2	1 Hes 20 No	- /	☐ ER/Outpatie			- + C   Huising						
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SIO endi eath.	cat	Accident investigation		10	М	1 🗆	Yes 2 □ No						
Division  or Attending after death. Director: After	Ę	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, st city)	reet, fact	ory, office		28f. Location City or	n (Street a Fown, Sta	and Number te)	or Rural	Route Nur	nber,
Les of rs aff	Certification:												
DIVISIO To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical		sician: To the best of my k ner: On the basis of exami and manner stated.										s)
thin the comple	Med	29b. Signature and title of certified			2	29c. License	e number		29d. D	ate signed (	Month, D	ay, Year)	
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/		TYK	-			X	0083	>	1	114	NC	06	
		30. Name and address of person who											
N 9-3		31. Date filed (Month, Day, Year)	32. Registrar's Sig	maturo			Takoma	Park, 1	MD 20	912			
St Regis	ate		2006 See as a	K 4	PORAL.	Care Al							

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			1 - For State Registrar	Otato of Maryti		rtificate of		Reg.	2000	35818
	P 4. *		Decedent's Name (First, Middle,	Last)				2. Date of Death	10.	3. Time of Death
	Physici Medic		Happiett	Rebacc	p	188		OCTOBER	18 2006	3:00 A M
	Examin		4a Facility Name (If not institution,		. /	4b. City, Town, o	or Location of Death		4c. County of Deat	
4		<u>.</u>	Gladys Spellm	AN NURSING	Home	Chare	Rly		PRINCO (	RORGES
	Funeral		5. Social Security Number	i. Sex 7. Age (In y	rrs. last birthday)  Yrs.	Months Days		8. Date of Birth (Month, Day, Ye	ar) 9. Birt	hplace (State or Foreign juntry)
	Director		Usual Residence of Decedent	~ 0	0 113.			CHOBER 2	7,1917 M	ARYLAND
	yland	Ì	10a. State 10b. County	/ 10c.	City, Town or Lo	ocation				10d. Inside City Limits
	B-f el	ctor	MARYLAND PRINCE	a Georges Z	BRANde	WINE				1 Pres 2 No
	or 28	Director	10e. Street and Number	1: 0	1	10f. Zip Code		10g.	Citizen of What Co	untry?
	ath w	rai	11301 North	Keys KOAG	/	204	13		USA	
	items	Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No	n U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	
38	urs aff	byF	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify: 15	Plack
21215-0036	2 hot	ted	15. Decedent's		16a. Dece	dent's Usual Occup	pation	16b	Kind of Business/	Industry
215	ithin 7 ie. ien "r	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	during most of word)	king	1	1.
	filed within 72 hours after death with the Maryland Hygiene. sther then "naturel", or items 23a or 28s-f ehow ent, the Medical Exeminer must be multired at		12		1	omemi		(F) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Domas	40
and	ntal He of	Be	17. Father's Name (First, Middle, La	1 -1	et.		18. Mothers Nam	ne (First, Middle, Maio	en Sumame)	Keal
Maryland	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artment of Heatih and Mental Hygiene. ortant: If item 27 is marked other than "naturei", or items 23a or 28a-f show injury or other traumetic event, the Madical Examiner must be nutilised at in.	P	19a. Informant's Name/Relationship			na Address (Street	and Number or Su	ral Route Number, Cit	v or Town State 7	Tip Code)
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re,	of Head		20a. Method of Disposition		b. Place of Dispo	osition (Name of matory or other pla	cel		Location - City or	Town, State
Ĕ	Pages nent of ant: If it ury or o		1  Surial 2  Cremation 3 4  Donation 5  Other (Spe		LARULAN	ich Veta	CAN 10-2	27-06 CH	altanha	H MARULAN
Baltimore,	permit. Page Department of Important: If any injury or ance.		21. Signature of Funeral Service Li	:en ee	2	2. Name and Addre	ess of Facility Ac	VANS FUNE	d HUNE A	DA.
ш	20599		Llyl	Ser 1	9/ 2	0605-AG			asco, Ha	7,1
			shock, or heart failure. List or	omplications that caused the day one cause on each line.	eath. Do not en	- 1	_	or respiratory arrest,		Approximate Interval Between Onset and Death
141	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	ie _1	ntarcth	المار			ondor and boarn
	Examiner			Due to (or as a cons	1	10				
	· · · · · · · · · · · · · · · · · · ·	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Cw Ceph) Due to (or as I cons	sequence of):	94				
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o,	te be executed ysicien and ie burial-transit		resulting in death) Last	Due to (or as a cons	sequence of):	1				
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× 68	Attending Physician: The law requires that the death certifica rideath.  •ctor: After this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as the page 2 should be detached for use as the funeral director, page 2 should be detached for use as the page 2 should be detached for use as the funeral director.	Physician/Med	IF FEMALE:	23c. If yes, outcome of pre-	anancy					
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	s that	by Pi	Part II. Other significant condition	s contributing to death but not	resulting in the u	inderlying cause giv	ven in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ğ	en sig	ed						1 🗆 Yes	2 □ No 3 □ Pro	obably 4 Unknown
ecc	8 8	Completed						24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
<u> </u>	The cate h	Sol						performed 1 ☐ Yes 2 ☐ 1	death?	V
Zi Es	certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			-	th (Check only one)		
Division of Vital Records,	Phys ral dia	5	1 Yes 2 No 27 Manner of Death	I L Inpatient 2	28b. Time o	11 3 DOA	4 Nursing Ho	ome 5 Residence 28d. Describe how in		cify)
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Visi	Atter	Ifica	3 Suicide 6 Could no determin	ad   286. Place of Injury - A	t home, farm, str	reet, factory, office		28f. Location (Street	and Number or Ru	ral Route Number,
	rs afte	Certification:	- Institute	building, etc. (Spe	ecity)			City or Town, Sta	110)	
	To the Hospital or Atlending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	icai	(Check only 2 Medical E)	Physician: To the best of my is aminer: On the basis of exam	knowledge, deat	h occurred at the tir	me, date and place,	and due to the cause	(s) and manner as	stated.
	thin 2 the 1 the mplet	Medicai	one)  29b. Signature and title of certifier	and manner stated.		29c. Licens			Date signed (Month	
}	F 3F 8		· Me	2. Caro		7777	<b>1</b>	1.2	112	u, rear/
(			30. Name and address of person wi	o completed cause of death.(I	tem 23a) (Type.	Print)	3//	15	147/6	06
	B		Oshnell	Cumberbatch	8410	//	n Ave	Lander P	11) 20	785
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	Physici	an	Decedent's Name (First, Middle, Last					Date of Death     Month	Day	Yeer	3. Time of De	ath
	/Media			Guillermo		Marasig		October	22, 20	06	2022	М
	Examir	ner	4a. Facility Name (If not institution, give Shady Grove Adver				or Location of Death		4c. County o			
	Company		5. Social Security Number 6. Se			If Under 1 Yea	ockville  If Under 24 Hrs.	8 Date of Birth		tgom(		
	Funeral Director			M 2□F 66		Months Day		8. Date of Birth (Month, Day, Ye May 4, 1	940 1	Count	ace (State or Fity) ippines	_
2	ith the Maryland or 28a-f ehow	Director	10a. State 10b. County  Maryland Montgom  10e. Street and Number		y, Town or Loc		ntgomery Vi		Citizen of Wh		od. Inside City L 1 ∰Yes 2	
Z	death with the ms 23a or 28a Lmust be not	alD	19319 Club House	Road #302			20886		Philip	pine	es	
M+rA-Sigan	P 5 3	d by Funeral	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	S. 13. W	/as Decedent of Yes, specify Cu ☐ Yes 2 (25)No	Hispanic Origin? (Spo ban, Mexican, Puerto o <i>Specify:</i>	ecify Yes or No- Rican, etc.)	14. Race Black, Specify:	White, e		
_ <u>₹</u> %	72 hours "natural",	ete	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Deced (Give I	ent's Usual Occi	upation e during most of worki ed)	ng 16b	. Kind of Bus	ness/Ind	ustry	
21212	filed within Hygiene.  Hygiene.  other than "	Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5+)			<sup>ed)</sup> Supervisor		Priv	ate		
$G_{u}$ . Hermo, $M_{\star rA-5}$ 8altimore, Maryland 21215-0036	s 1 and 2 should be filed within Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the M	To Be	17. Father's Name (First, Middle, Last)  Juan Marasigan				Esperar	e (First, Middle, Maid nza Villap	ando			
16 T	and 2 sh ealth and n 27 le m		19a. Informant's Name/Relationship (Ty Rosario Marasiga	n (Wife)	19319	Club Ho	ouse Rd, #3	11 Route Number, Ci 302, Monto	y or Town, Si Jamery	ate, Zip ( Vill	<sup>Code)</sup> .age, MI	)
ス/   imore	Pages 1 a lent of Hes nt: If Item ry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)	omoral monifoldito		ition (Name of atory or other pl	ace) 1 Pk   11/4,		Location - C		<sub>vn, Slate</sub> ippines	,
Balti	permit. Pages Department of Important: If I eny injury or once.		21. Signature of Juneral Service Licens	Hen	22.	Name and Add	ress of Facility Ren polis Road	don/Hale	Funera	.1 Ho	me	>
68760,	Physician and physician and physician and physician and physician and street st	dical Examiner	23a. Party Enter the disease, or complished, or heart failure. List only or lipsed as a condition resulting in death)  Sequentially list conditions, and list of the cause. Enter Underlying cause. Enter Underlying cause, Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to	Infar		ing, such as cardiac c	r respiratory arrest,			Approximate Interval Betwee Onset and Dea 1 day	
P.O. Box (	requires that the death certifica een signed by the attending ph nould be detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3□E	Ectopic pregnand Other <i>(specify)</i> _	су		23d. Date of Month		y Day Year	
rds, P	quires that in signed t	2	Part II. Other significant conditions cor Athrosclerosis	tributing to death but not resu	Iting in the und	derlying cause g	iven in Part I.	23e. Did tobacc			cause of death	
Division of Vital Records,	The law requir	Completed						24a. Was an autopsy performed	24b. We	re autops or to comp oth?	sy findings avai pletion of cause	lable e of
<u>la</u>	ifficat or, pa		25. Was case referred to medical					1 ☐ Yes 2 🖸	No 1	Yes 2	!□ No	
<u> </u>	Physician: The la r this certificate har ral director, page 2	ToB	examiner?	ospital: 1 ☐ Inpatient 2XI	R/Outnationt	3□ DOA O	26. Place of Death	ne 5 Residence	6 🗆 Osh	(0 1-1		
9	g Ph		27. Manner of Death		28b. Time of	28c. Inju		8d. Describe how in		(Specify)		
sior	Attending r death. ector: After	catio	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		Injury	M 1	Yes 2 □ No					
Divi	itel or Al	Certification;	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	)			81. Location (Street City or Town, Sta	ite)			
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funsral Director: After th completely filled in by the funeral	Medical	29a. Certifier Certifying Physics (Check only one) 2 Medical Examination	ician: To the best of my know er: On the basis of examinati and manner stated.	rledge, death on and/or inve	occurred at the t stigation, in my	ime, date and place, a opinion, death occurre	nd due to the cause d at the time, date a	(s) and manning	er as stat I due to ti	ted. he cause(s)	
	To the within 2 To the complet	2	29b. Signature and title of certifier  Butt In	MD			se number	L.	Pate signed (A			
CA	2 (6)		30. Name and address of person who co Brett Gamma	appleted cause of death (Item 9901 Media	23a) (Type, Pi	rint) enter	1986 Drive, Roc	kville.	md z	1085	50	
	Sta Registra		31. Date filed (Month, Day, Year)  OCT 2.6.2006	Registrar's Signati	ire feed	7	b			o verme	100	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 1010 AM 2000 Octoba 28 Joan Maenner /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Union Memorial Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🖾 F Yrs Oct. 8,1939 67 Maryland Director 219-38-0774 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 'natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2K No Director Frederick Emmitsburg Maryland 10g. Citizen of What Country? 10e. Street and Number 16150 St. Anthony Road 21727 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or Ite 1 □Yes 2 No f Yes, Give fear or Dates: 1 k Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify Specify: þ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 7 is marked other than "nature traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Pastoral Life Director Baltimore Archdiocese 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nancy Kelly ٩ John Maenner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) int of Health at: If Item 27 is 16150 St. Anthony Road, Emmitsburg, Maryland 21727 Sr. Marietta Culhane/Friend 20b. Place of Disposition (Name of cemetery, crematory or other place)
Our Lady of Angels
Convent Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State Department of Important: If any injury or once, 4 □ Donation 5 □ Other (Specify) Nov. 2,2006 | Aston, Pennsylvania 21. Signature of Funeral Service Licens 22. Name and Address of Facility Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part1. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one of use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician stevene Tyean /Medical Due to (or as a consequence of): Examiner JUSIS Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to ( as a consequence of) Examiner Respirato Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 Ø No 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of After t 1 Natural 5 Pending investigation To the nosperation 24 hours after death.

To the Funeral Director; Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier October 28 2006

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

toward

30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt)

2006

OCT 3 0

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [ Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** October 26, 2006 Katherine L. Miles 6:28 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c County of Death Examiner Filcare Home Clear Spring Washington | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. | 16,1917 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√ F 217-10-0061 89 Yrs Maryland Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Iteme 23a or 28a-f show the Medical Examinar must be notified at Maryland Washington Clear Spring 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13016 Spickler Rd. 21722 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedenf Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. ☐Yes 2☐No fYes, Give X rear or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify ģ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Efementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill iment of Health and Mental H tant: It Item 27 is marked off lury or other traumatic even William K. Cutsail Marie Staley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William E. Miles / Son 9202 Links Rd., Walkersville, MD 21793 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: It eny Injury or once. Mt. Olivet Cemetery 11/1/2006 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stautter Funeral Home 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part. Enter the disease, or complications the leaved the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ALZHEIMERIS DEMENTIA **Physician** 4 YRJ /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death buf not resulting in the underlying cause given in Part I. 23e. Did tobacco use confribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Monknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No certificate 2 **N**o To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 € No 1 fnpafient 2 2 ER/Outpatient 3 DOA this After this funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation s after dec. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Pface of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

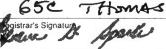
31. Date filed (Month, Day, Year) 32. OCT 3 0 2006

A. DONELSON, ND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

29a. Certifier



29c. License number

021936

NOPHION

29d. Date signed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. UUS Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death . 2006 Month **Physician** Moore D. Jeanie 1:20 A. October 14, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Laurel Regional Hospital Prince George's Laurel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min 240-82-0554 1 M 200 F 58 March 19 North Carolina Yrs Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event. If a Miscical Examinar must be notified at **Beltsville** Prince George's Maryland 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20705 4625 Quintby Avenue U.S.A. by Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiane. Important: If tem 27 is marked other than "natural", or ites any injury or other traumatic event. It a Micigal Examinat 1 X Never Married 2 ☐ Married 1 ☐ Yes ŽŽNo If Yes, Give Year or Dates: Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accountant Giant Food Store (Retired) 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Paul Moore Earma Everett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1200 Holbrook Street, N.E. Apt. #2 Washington, D.C. Cherita N. Moore-Porter (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Murial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Mount Olivet Cemetery October 20, 2006 Washington, D.C. 21. Sig stury of Funeral Service Licensee 22. Name and Address of Facility Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. Approximate Interval Between Onset and Death 3 days 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Right Cerebral Infarct **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in resolute cause. Enter Underlying Cause (Disease or injury Dualty for as a prinse menos off Examine The law requires that the death certificate be executed anding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Day Month Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Cardionyopathy, Diabetes Mellitus TypeII 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Hypertension, Coronary Artery Disease 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 1 ☐ Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 XX ို 1 🔯 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Affer Injury 1 Natural 5 Pending To the Hospitat or Attendir within 24 hours after death. To the Funeral Director: At completely filled in by the fu death. 1 TYes 2 □ No 2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D46120 October 14, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) F. Deleon, MD 10724 Little Paturent Pkwy, Columbia, Maryland 21042 31. Date filed (Month, Day, Year) OCT 2 3 2006 3. Registrar's Signature State Registrar

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	Physici /Media	al	Annie Magdaler 4a. Facility Name (If not institution, give s	e McDowell	4b. City, Town, or Loc	Octobe	er 14, 2006 10:15PM
	Examir	er 	Washington Adve		Takoma	Park	Montgomery
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda 79 Yrs.	v) If Under 1 Year If I	Under 24 Hrs. 8. Date of Bir ours Min. (Month, Da March	th y 1927 9. Birthplace (State or Foreign Country) Country
	Director		244-42-5223 Usual Residence of Decedent	79		- Indicat	DIACCI
	arylan show	<u>_</u>	10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits 11☑ Yes 2 □ No
	the Ma	Director	DC 10e, Street and Number	Washing	ton		10g. Citizen of What Country?
	3a or	Dir	3616 Horner Plac	ce SE	20032		United States
	death	Funeral			J. Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin? (Specify Yes or No lexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	d within 72 hours after death with the Maryland Jiene. r than "naturel", or items 23a or 28a-1 ehow The Madical Examinar must be notified at	by Fu	1 Never Married 2 Married 3 XWidowed 4 Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		pecify:	Specify: Black
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d 2	H H H	e Co	12 17. Father's Name (First, Middle, Last)	2 0		Mother's Name (First, Middle	
Maryland	0 0 0	To B	Calvin Smith		F	Ruth Ann Atk	cinson
lary	2 should and Men ie marke aumatic		19a. Informant's Name/Relationship (Ty	pe, Print) 19b. Ma	iling Address (Street and	Number or Rural Route Numb	per, City or Town, State, Zip Code)
	s 1 and 2 should Health and Meritem 27 ie marke other traumatic		Ruth Lawrence/ 20a. Method of Disposition	20b. Place of Dis	position (Name of	Date	ington, DC 20018  20c. Location - City or Town, State
Baltimore,	000===		1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Cedar	rematory or other place)	October 20, 2006	Suitland, Md.
altii	permit. Pag Department Important: i any injury c		21. Signature Fundal Service Liouns	to an	22. Name and Address of	Facility Murray I	Euneral Home
œ_	8858		Kle Shaun C	0800 4	804 Georg	ia Ave. NW W	√ashington, ĎC _
			shock, or heart failure. List only or	cations that caused the death. Do not e ne cause on each line.	enter the mode of dying, si	uch as cardiac or respiratory a	arrest, Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	METASTATIC  Due to (or as a consequence of):	ENDOMETR	IAL CANCET	2 mark
	Examiner		Sequentially list conditions	SERSIS			a lwat
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):			
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8760,	cate be executed physicien and the burial-transit	dical E	L.	d			
9	ntificat ng phy s as th	Medi	IF FEMALE:				
Вох	eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?		B Ectopic pregnancy		23d. Date of delivery  Month Day Year
o.	that the de led by the detached	hysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown			
s, P	Se 75 6	by P	Part II. Other significant conditions con	atributing to death but not resulting in the	underlying cause given in		tobacco use contribute to the cause of death?  Yes 2 \sum No 3 \superpress Probably 4 \sum \sum \sum \sum \nu nown
ord	v require been sig should b	eted				24a. Was	
Records,	The law sete has t page 2 s	Completed				auto	prior to completion of cause of death?
Vital		0	25. Was case referred to medical		26	Place of Death Check only	
of V	Q 55	To B	examiner? 1 □ Yes 2区No	lospital: 1 VInpatient 2 ER/Outpat		4 Nursing Home 5 Res	
o uc	Jing Ph After th funeral	ion:	27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury	y Work?	28d. Describe	how injury occurred
Division	tend leath tor:	Certification:	3 Suicide 6 Could not be	28e. Place of thiury - At home, farm,		28f. Location	(Street and Number or Rural Route Number, wn, State)
D	rs efter rs efter ral Direction by	Cert	4  Homicide	building, etc. (Specify)		City of 10	wn, State)
	To the Hospitel or At within 24 hours effer of to the Funeral Direct completely filled in by	edicai	(Check only one)	<ul> <li>aician: To the best of my knowledge de ner: On the basis of examination and/or and manner stated.</li> </ul>	ath occurred at the time of investigation, in my opinion	date and class, and due to the on, death occurred at the time	cause(s) and mannar as stated, , date and place, and due to the cause(s)
	o the	Med	29b. Signature and title of certifier	and manner stated.	29c. License nu		29d. Date signed (Month, Day, Year)
	(9)		M.S.No	7	0-1	7874	10-16-06
	OR			ompleted cause of death (Item 23a) (Type 3 7 1 7 - 38 7)	pe, Print)	E CITY M.	0 20721
	9	ate	S- M. NAYAR M 31. Date filed (Month, Day, Year)	32. Registrar's Stanatus	No comina	211)10	y 1 - 6-
1	Regist		OCT 2 3 2006	em f. popular			

			For State Registrar	State of	Marylan	id / Depa	artment of F	Health and N Death	lental Hy	giene	06	35	824
			Decedent's Name (First, Middle,	Last)					2. Date of De	ath		3. Time	of Death
	Physici /Media		Carolyn R	. IV	1cG1ynn	ì			Month Octobe	Day er 20, 1	Year 2006	1:1	o a <sup>M</sup>
	Examir		4a. Facility Name (If not institution,	give street and numb	ber)		4b. City, Town, o	r Location of Death			ty of Death	1	.0
			Suburban Hospita	al			Bet	hesda		Montgo	omerv		
	Funeral		5. Social Security Number	5. Sex 7. 1 ☐ M <b>2√</b> 3√F	. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th		olace (Stat	e or Foreign
	Director		164-24-0788 Usual Residence of Decedent		9.8	Yrs.			_	, 1908		, 1sylv	ania
	and w		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						City Limits
	Many 1 sh	ō	Marry land Montage			_							es 2 No
	1 the	Director	Maryland Montgor  10e. Street and Number	nery		Rock	ville 10f. Zip Code			10g. Citizen of	What Cour	ntry?	
	burs after death with the Marylan rai, or Itams 23e or 28e-1 show	<u>=</u>	4601 Creek Sho	ore Drive			,	0852				y .	
	deatl	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.	S. 13. V		tispanic Origin? (Sp an, Mexican, Puerto	ecity Yes or No	- 14. Ra	SA ce - Americ	an Indian,	
g	or Ite		1 Never Married 2 Marrie	Armed Force 1 Yes 2 If Yes, Give	No No	1			Rican, etc.)		ick, White,		
003	72 hours "natural",	d by	3 □XWidowed 4 □ Divorced	Year or Date	es:		☐ Yes 2፟X No	Specify:		Speci	<i>か</i> :Whit	e	
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2	be filed within 72 hours after death with the Maryland the Hygiene. The Hygiene. d other than "natural", or Itams 23a or 28a-f show event, I're Medical Examinations and be mullied at	ပိ	17. Father's Name (First, Middle, La	ast)		HOM	emaker	18. Mother's Name	a (First Mindella		Home	<u> </u>	
9		To Be	Ferdinand Roos	,				Margaret		Walden Sumai	110/		
Marviand 21215-0036	2 should be filed within 72 ho 2 should be filed within 72 ho is marked other than "natur reumstic event, Ina Mazilcal.	-	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailin	g Address (Street	and Number or Run		r. City or Town	State Zin	Code)	
Š	nd 2 alth a 27 is		Owen B. McGlynr	. Jr. / So	n			ore Drive					
e e	item		20a. Method of Disposition		20b. P	lace of Dispos	sition (Name of patory or other place		Date	20c. Location	- City or To	wn, State	
ع ع	Page nent nrt: If		1 ဩxBurial 2 □ Cremation 3  '4 □ Donation 5 □ Other (Spe		St.	Marv's	Immaculate Cemetery	Conception	Oct. 2	23	o = D		10.7
Baltimore.	permit. Pages 1 and 2 should Department of Health and Men Importent: If them 27 is marke any injury or other treumatic once.		21. Signature of Funeral Service Li	censee		22	Name and Addres	ss of Facility			es-Bai	rre,	PA
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			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that cau-	sed the death	. Do not ente	er the mode of dyin	g, such as cardiac o	or respiratory ar	rest,		Approxim Interval B	ate
	Physician		Immediate Cause (Final disease or condition	Myoca:	rdial	Infarc	tion					Onset and	
	/Medical Examiner		resulting in death)	Due to (or	as a consequ	ience of):	CTOIL						
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×o	eath certifi attending   for use as	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor						23d. Da	te of delive	rv	
~ B	ne death the atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant	n 2 □ Fetal t at time of de		Ectopic pregnancy Other (specify)					Day	Year
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S. I.	requires that the death certificeen signed by the attending Inould be detached for use as	þ	Part II. Other significant conditions	s contributing to death	h but not resu	lting in the un	derlying cause give	en in Part I.	23e. Did to	bacco use cont	tribute to the	e cause of	death?
Are La	w require been si should b	Completed							1 🗆 Y	es 2□No	3 Proba	ably 4 🛚	Unknown
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J <u>"</u>	T at	S							perfor	med?	death?	2 No	Cause of
ر ر Viital	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Harrian				26. Place of Death	(Check only or	7e)			
7 6	his his	2	1 Yes 2 No  27. Manner of Death		atient 2 🗆 E			4   Nursing Hor				)	
Lynn sion of V	ing After fune	ion	Natural 5 ☐ Pending	28a. Date of Ir (Month, L	Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe h	ow injury occuri	red		
- O	Attending r death. actor: After by the fune	lica	2 Accident investigat 3 Suicide 6 Could not	ha	Injuge - At hor	me farm etm		/es 2 □No	28f. Location (S	trant and Nomb		D	
S in	after after Dire	Certification;	4 Homicide determine	building,	etc. (Specify,	)	et, factory, office		City or Tow	n, State)	er or Hurai	Houte Nui	mber,
2	spite hours nere	aic	29a. Certifier 1 Certifying	Physicien: To the be	st of my know	vledge, death	occurred at the tim	e, date and place, a	and due to the c	ause(s) and ma	inner as sta	ited	
2	To the Hospitet or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical	(Check only 2 ☐ Medical Ex	aminer: On the basis and manner	s of examinati	on and/or inve	estigation, in my op	inion, death occurre	ed at the time, d	ate and place,	and due to	the cause	(s)
	To the To the Complex construction of the Complex construc	Σ	29b. Signature and title of certifier				29c. License	number	2	9d. Date signed	d (Month, D	ay, Year)	
	9		1 SI /Solu	1			D28	064		Oct	ober	20,	2006
			30. Name and address of person wh										
			Edward Bodurian 31. Date filed (Month, Day, Year)				n Avenue	, #515, C	hevy Ch	ase, MD	2081	. 5	
	Stat Registra		OCT 2 3 20	06 January	strar's Signati	Sperk	E .						

		1	For State Registrar	State of N	/larylan				ealth a Death	and M		jiene eg. No./	2006	358	25
			Decedent's Name (First, Middle, Last	st)							2. Date of Dear		V	3. Time of De	eath
	Physicia	-	Kathleen France	s Morris	son						Month Octobei	Day	Year 2006	12:00	рм
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City.	Town, or	Location of	of Death			County of Dea		
•	⊏xamın	er					G:	7	G				<b>W</b> -		
	Euparal		Manor Care- Whea  5. Social Security Number 6. S		Age (In yrs.	last birthday)	If Unde	r 1 Year	Spri If Under	24 Hrs.	8. Date of Birth	1	9 Bi	ntgomery thplace (State or F	Foreign
	Funeral Director			□M 24C)F	66	Yrs.	Months	Days	Hours	Min.	(Month, Day March 2	5 <sup>Year)</sup> 1	940 Å	labama	
		t	Usual Residence of Decedent												
	yland sow		10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City	
	Mar F	to	Maryland Montgom	nery	E	Betheso	đa							1 🗆 Yes 2	No No
	r 288	Directo	10e. Street and Number				10f. Zij	p Code			1	0g. Citiz	en of What C	ountry?	
	n 72 hours after death with the Maryland "naturel", or Items 23a or 28a-f show exical Examinat must be notitied at		10250 Westlake	Drive, #	108				2081	7		US	A		
	ms 2	Funeral	11. Marital Status	12. Was Deceder		.S. 13.	Was Dece	dent of Hi	ispanic Ori	gin? (Spe	city Yes or No-	1		erican Indian,	
0	ther ite	F	1 Never Married 2 Married	Armed Force						i, Puerto i	Rican, etc.)		Black, Wh Specify: Wh		
<u> </u>	ol', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	s:		1 🗆 Yes	213 NO	Specify:				Specify: ****	100	
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Ž	within 72 ene. then "nat	ple	Elementary/Secondary (0-12)	College (1-4c	or 5+)	life.	DO NOT L	ise retired	)						
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<u> </u>	ould b	10	Thomas Matthew M	Morrison_					Glor	ia M	ay Jiro	n			
ĕ	s me		19a. Informant's Name/Relationship (	Туре, Print)		19b. Maili	ng Addres	s (Street a	and Numbe	er or Rura	l Route Number	r, City or	Town, State,	Zip Code)	
Σ	es 1 and 2 should be t of Health and Mental h litem 27 is marked of r other traumatic ever		Deborah Anne Morn	ison/ Si	ster	981	l Bri	stol	Squa	re L	ane, #20	01,	Bethes	da, MD 20	0814
<u>e</u>	ten item		20a. Method of Disposition	70	20b. P	Place of Dispo	sition (Na	me of other plac	е)	0	ate	20c. Lo	cation - City o	r Town, State	
ᇎ			4 □ Donation 5 □ Other (Specif	Entombra	ent Gat	e of He	aven C	'emete	ry	Oct 8	ber 28	, Sil	ver Sp	ring,Mar	vland
offinore,	permit. Pag Department Important: I any injury o		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification of Funeral Service Licents)	1500	CITE	Man a	Name a	m nd Addres	ss of Facilit	ing	Funeral	Hom	e Inc		
Ď.	Ded page		) lama c	Dala	-	50	00 Un	iver	sity	Blvd	, W, Si	lver	Sprin	g, MD 20	901
			23a. Part1. Enter the disease, or com	plications that caus	sedvine deat	h. Do not ent	er the mo	de of dyin	g, such as	cardiac c	r respiratory arr	est,		Approximate Interval Between	200
	Diameter team		shock, or Neart failure. List only Immediate Cause (Finat	one cause on eacr	ı ine.									Onset and De	
>	Physician /Medical		disease or condition resulting in death)	a Conges	tive F as a conseq		ailu	re			<del></del>			Year	S
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	ted nsit	- E	cause. Enter Underlying Cause (Disease or injury	Diabet	es	,								Year	s
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	death certific e attending p id for use as i	Physician/Me	IF FEMALE:	23c. If yes, outcor	ne of pregna	ancy							3d. Date of d	alivary	
Box	atten for u	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant	2 ☐ Feta	Ideath 3	∃Ectopic p ∃Other (s					- 1	Month	Day Ye	ar
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₾.	that ti ed by detac		Part II. Other significant conditions	contributing to deat	h but not res	ulting in the u	nderlyina	cause giv	en in Part I		23e. Did to	bacco u	se contribute	to the cause of dea	ath?
Division of Vital Records,	se Ge	ğ									1 D Y	es 2[	□No 3□F	Probably 4 ⊠Un	known
5	w require been si should I	Completed	Atrial Fibrillati	on, Cere	bral \	/ascula	ar Ac	cide	nt		-				
ဝ	has b	Jg.									24a. Was a autop: perfor	SV	24b. Were a	autopsy findings av completion of cau	vailable use of
=		ပ္ပ									1 ☐ Yes		death? 1 ☐ Ye	s 2□ No	
<u>=</u>	Attending Phyaician: The r death. ector: Alter this certificate h.by the funeral director, page	Be	25. Was case referred to medicat examiner?							of Death	(Check only or	70)	<del> </del>		
=	hyai this o	မ	1 ☐ Yes 2 No	<del></del>		ER/Outpatie			- Z(140		me 5 Resid			ecify)	
_	ding P. h. Atter t funera	ü	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of I (Month,	njury Day Year)	28b. Time o Injury		28c. Injur Wor			28d. Describe h	ow injur	y occurred		
<u> </u>	eath.	Certification:	2 ☐ Accident investigation				М		Yes 2 🗆						
Ë	I or Attendate after deat Director:	ţ.	3 ☐ Suicide 6 ☐ Could not be determined	1 286. Place of	Injury - At he etc. (Specif	ome, farm, st fy)	reet, facto	ry, office			28f. Location (S City or Tow	treet an n, State	d Number or I )	Rural Route Numbe	e <i>r</i> ,
	ital c irs af rei D led ir														
	t hours tuneral	edical		hysician: To the be miner: On the basis											
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	led	one)	and manner			-								-
	Son To To To To To To To To To To To To To	Σ	29b. Signature and title of certifier	0. 0	V <sub>ery</sub> ne	200	29		e number	7			-	nth, Day, Year)	_
١	10	3	Annon	udillo	elen	14-E	)	DC	005	163	6	0	ctober	20, 200	6
	<b>1</b> ~		30. Name and address of person who	completed cause of	of death (Iter	m 23a) (Type,	Print)	nuc	#200	C.	lver Sp	rin~	MD 30	902	
			Anuradha Arun				. AVE	iiue,	πΔ09	, pT	тvет рр.	<u> </u>	, FID ZU	J U &	
	Sta Begisti		31. Date filed (Month, Day, Year)		istrar's Signa	ature	action								

	4	1- For State of Maryland / Departm Certific	ent of Health		tal Hygier	71116	35826
Physicia: /Medica		1. Decedent's Name (First, Middle, Last)  Mary Elizabeth Marks		2. C	ate of Death	Day 2006	3. Time of Death
Examine			city, Town, or Location	of Death		4c. County of Death	
Funeral Director			der 1 Year If Under	r 24 Hrs. 8. D	ate of Birth Wonth, Day, Ye L. 02,	9. Birth	nplace (State or Foreign untry) laware
Maryland a-f show		10a. State 10b. County 10c. City, Town or Location  Maryland Cecil Elkton	า				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
ath with the 123a or 28	Funeral Director	10e. Street and Number 10f. 960 West Pulaski Highway	Zip Code 21921			Citizen of What Cou	
lore, Intervially Z1Z12-0030  ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene.  If Item 27 is marked other than "neturel", or Items 23a or 28a-1 show or other traumatic event, the Mudical Examinar must be notified at	by Fune	1 □ Never Married 2 □ Married   1 □ Yes 2 🔀 No	ecedent of Hispanic Or specify Cuban, Mexican s 2 No Specify:		res or No- n, etc.)	14. Race - Amer Black, White Specify: Wh:	, etc.
ithin 72 hours af	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	work done during mos Tuse retired)	•		Kind of Business/li	ndustry
d be filed w batal Hygien ced other th	e d	17. Father's Name (First, Middle, Last)		er's Name (Firs	t, Middle, Maid	,	
Te, Marylall and 2 should be Health and Mental tem 27 is marked of	<u>o</u>		ess (Street and Number		ite Number, Cit	y or Town, State, Zi	2.192.1
Dattinore, permit. Pages 1 ar Department of Hea Important: If Item; any Injury or other		becca Schierbaum/Daughter 960 W.  20a. Method of Disposition 1	Name of or other place)	Date	20c.	Location - City or T	own, State
permit. Pa Departmen Important any Injury		21. Signature of Funeral Service Licensee 22. Name	and Address of Facility  South Mai	ity Cro	ouch F	uneral H	Home 21901
Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the n shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a	node of dying, such as	s cardiac or resp	piratory arrest,		Approximate Interval Between Onset and Death
/Medical Examiner	<u>.</u>	Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):					
ate be executed hysician and the burial-transit	Схаги	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):					
ertificate be ling physicis e as the bu	Medical	d					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: Atter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Diversion Medical Examir	iysiciai	23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 3   Ectopic 4   Pregnant at time of death 5   Other 9   Unknown	c pregnancy (specify)			23d. Date of deliv Month	ery Day Year
w requires that been signed be should be deta	֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	Part II. Other significant conditions contributing to death but not resulting in the underlyin Failure to Thirty	g cause given in Part I.	l. 2		use contribute to t	he cause of death?
The law requires that has been spage 2 should	in in in in in in in in in in in in in i				4a. Was an autopsy performed?  ☐ Yes 2 🗆 1	prior to co	opsy findings available impletion of cause of
Physician: The Physician: The ral director, page	2	25. Was case referred to medical examiner?  1 Yes 2 No	DOA Other: 4 Nu		Residence	6 □Other (Special	(y)
tal or Attending F rs after death. at Director: After ed in by the funer		1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation 3 Suicide 6 Could not be determined determined	28c. Injury at Work?  1 Yes 2 I	No	Describe how in	ury occurred  and Number or Rure	al Route Number
To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the tu		29a. Certifier  (Check only one)  29 Medical Examiner: On the basis of examination and/or investigations.	ed at the time, date an	nd place, and di	ity or Town, Sta	c) and manner as a	stated.
To the Hosp within 24 hou To the Fune completely file		and mariner stated.	29c. License number		29d. D	ate signed (Month,	Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	2 Paral	5/0	Oct	ober 23 Wark D	2006
State Registrar		31. Date filed (Month, Day, Year)  OCT 2 3 2006  OCT 2 3 2006	- 1-ev/0	5 MUTE	A /V.D.	WAK D.	e 19+02

			1 - For State Registrar	State of Ma		partment of F ertificate of			ene 2006	35827
			Decedent's Name (First, Middle, La	ist)				2. Date of Deatl	1	3. Time of Death
	Physici /Medio		Marjorie G.	McColgan				Novembe	r 5, 2006	9:20 P <sup>M</sup>
	Examir		4a. Facility Name (If not institution, given	re street and number)		4b. City, Town, o	r Location of Deat		4c. County of Deat	1 - 1 - 1
			Hearthomes at Li			Linthi			Anne Ar	unde1
	Funeral Director		5. Social Security Number 6. \$ 480-03-5924	Sex 7. Age 1□M 2\(\text{\Omega}\) F 9(	(In yrs. last birthda Yrs.	Months Days	If Under 24 Hrs Hours Min.		9. Birt 216 Iov	hplace (State or Foreign nuntry)
	מ		Usual Residence of Decedent					0/15/1	710 101	wa
	how	_	10a. State 10b. County	1	10c. City, Town or					10d. Inside City Limits
	Ba-f	cto	Maryland Anne Ar	undel	Crow	nsville				1 ☐ Yes 2 ☐ No
	with ti	급	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	eath	erai	1100 Bristol Way	12. Was Decedent E	ver in II S 1	3. Was Decedent of H		Consider Van or No.	USA 14. Race - Ame	doon Indian
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Importent: if Item 27 le marked other than "naturel", or items 23e or 28e-f ehow any fujury or other traumatic event, the Madical Examinar must be notified at ODGe.	by Funeral Director	1 Never Married 2 Married 31/2 Widowed 4 Divorced	Armed Forces?  1  Yes 2 X No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 🎇 No	Specify:	to Rican, etc.)	Black, White	
Õ	2 ho	ted	15. Decedent's E		16a. De	cedent's Usual Occup	ation	1:	6b. Kind of Business/	Industry
21215-0036	vithin 7	Completed	(Specify only highest grant Elementary/Secondary (0-12)	College (1-4or 5+	) life	ve kind of work done  DO NOT use retired	during most of wo. d)	rking		
io D	Hygie ther t nt, in		12th 17. Father's Name (First, Middle, Last	1	Ho	memaker	18 Mother's Na	me (First, Middle, N	Home	
au	d be ental ked o	To Be		, Gloe					ohse	
ary	shound M	_	19a. Informant's Name/Relationship (		19b. Ma	iling Address (Street			City or Town, State, 2	Tip Code)
ž	and 2 alth a 27 le		Marjory M. Steve	ns/ Daughte	er 110	O Bristol	Way, Cro	wnsville,	Maryland	21032
altimore, Maryland	of He of He If Item or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	₹Removal from State	20b. Place of Dis	sposition (Name of rematory or other place	(a)	Date 2	Oc. Location - City or	Town, State
Ë	: Pag tment tent:		4 ☐ Donation 5 ☐ Other (Special	र्फ)	Maple H	ill Cemete	ry   11-	7-06	Gladbrook,	Iowa
Ba	Depermit Deper Impor any In		21. Signature of Funet Service Lice	1500					Kalas Fune igewater,	
			23a. Part1. Enter the disease, or corr shock, or heart failure. List only	plications that caused to	he death. Do not e	enter the mode of dyin	g, such as cardia	or respiratory arre	st,	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	CONGE	STIVE	HEART	FAI	LURE		Onset and Death
f	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):					
4	cuted nd ransit	Examiner	d any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c						
Ö,	ificate be executed g physician and as the burial-transit	I Ex	resulting in death) Last	Due to (or as a	consequence of);					
68760,	physic physic the b	edical		_ d						
_	n certif	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. Il yes, outcome ol		_			23d. Date of deli	verv
P.O. Box	The law requires thet the death certit lie has been signed by the ettending page 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown		3 □Ectopic pregnancy 5 □ Other (specify)			Month	Day Year
œ.	s thet	y P	Part II. Other significant conditions			underlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ğ	equire en sig ould b	ted	EHRONIC PA.	MENYS WI	Lone			1 ☐ Yes	2 □ No 3 □ Pro	obably 4 Unknown
Division of Vital Records,	law r	Completed by						24a. Was an autopsy	prior to d	topsy findings available completion of cause of
<u> </u>	cete							perform 1 Yes 2		2□ No
<u> </u>	iclan certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		iont 20 DOA Oth		ath (Check only one		Assisted
ot	Attending Physician: Ir death. ector: After this certifice by the funeral director, p	2	1 ☐ Yes 2 ☐ No  27. Manner of Death	1 Inpatient	2 ER/Outpat	IGIT 3LI DOX	4   Nursing n	lome 5 ☐ Resider 28d. Describe how	nce 6 AOther (Spec	Living
<u>o</u>	nding ath. r: Afte e func	ation	1 √Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day	Year) Injury		k? Yes 2 □ No		,	
Σİ	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		y - At home, larm,	street, factory, office		281. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	urs eff real Di									
	To the Hospital or Attending Physician: The law within 24 bours elder death, within 24 bours elder death. To the Funeral Director: Atten this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exam	nysician: To the best of miner: On the basis of e and manner state	ixamination and/or	ath occurred at the tim investigation, in my of	ne, date and place pinion, death occu	, and due to the cau irred at the time, dat	use(s) and manner as e and place, and due	stated. to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier			29c. License			d. Date signed (Month	
			monegi	ms		D57	531	N	VEMBER 5	2006
	10		30. Name and address of person who	completed cause of dea	ith (Item 23a) (Typ	e, Print)	·	11 0 11.		
	-0		31. Date liled (Month Day Year)	, 86011	e Signatura	May s	ule 20	7, rull	roulle,	My 21108
	Sta Registr	te ar	30. Name and address of person who have regarded and address of person who are represented as a second seco	J06	s signature	DENEL				•

State of Maryland / Department of Health and Mental Hygiens, Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Raymond Earl McCleary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Hagerstown Washington County Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Apr 25, 19 Birthplace (State or Foreign Country)
 PA 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Days **Funeral** 77 1(XM 2□ F Yrs. 218-24-1977 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then \*neturel', or itame 23a or 28a-f show eny Injury or other traumatic event, it a Madical Examinational be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a, Slate 10b. County 1 Yes 2 No Smithsburg Director MD Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21783 USA 22303 Pondsville Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo White Baltimore, Maryland 21215-0036 Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grit mill Bucket man 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 86 Naomi Pearl Hahn Eli Hale McCleary ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 22303 Pondsville Rd., Smithsburg, MD 21783 Annabelle McCleary wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Nov 1 2006 Waynesboro, PA 4 □ Donation 5 □ Other (Specify) Antietam Church Cem 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc. 21. Signature of Funeral Service Licensee Bacilerse 50 S. Broad St. Waynesboro, PA 17268 james 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Kidney hronic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Hypertension Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner Fibrillation Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Atv. al and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day signed by the atte in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No certificate funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မှ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After Injury 5 Pending investigation 1 Natural nours after death. Ineral Director: Aft y filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10130106 D060396 1126 0001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUM SHED 21740 MD ARID 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

	•	1 - For State Registrar		State	of Ma	ryland				lealth a D <i>eath</i>		ental Hy	giene Reg. No.	005	35829
1 to 1 p.	ke .	Decedent's Name (First, M.)	fiddle, La	ast)								2. Date of De. Month		Year	3. Time of Death
Physici /Medio		Dorothy Est	her	Mumaw								Novemb			4:50 A. M
Examir		4a. Facility Name (If not instit			umber)			4b. City	Town, or	Location of	of Death		4c. (	County of Deal	th
E A *	× ×	11006 Parkwood							_	rstow				Washing	
Funeral		5. Social Security Number 300-50-9070		Sex 1 ☐ M 2 🖫 F	_	(In <i>yr</i> s. Ii 55	ast birthday) Yrs.	Months	r 1 Year Days	If Under Hours	Min.	8. Date of Bird (Month, Da July13	h y, Year) 105	9. Birt	hplace (State or Foreign buntry)
Director		Usual Residence of Deceder				22	113.					Juryra	, 195.	1 (	hio
/land		10a. State 10b. Co				10c. City	, Town or Lo	cation							10d. Inside City Limits
Many Fish	to	Md. Was	hing	gton			Hag	erst	own						1 ☐ Yes 2 🛣 No
n the	Director	10e. Street and Number						10f. Zi	Code				10g. Citiz	en of What Co	puntry?
th wit	alD	11006 Parkwo	od 1	Dr.					21742	2				U.	S.A
ING Z IZ I 3-UU30 be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-1 show event, the Medical Evertinar must be rotified at	Funeral	11. Marital Status		12. Was De Armed F	orces?		S. 13. V	Vas Dece Yes, spe	dent of H	ispanic Ori n, Mexicar	igin? (Spec n, Puerto R	ofy Yes or No lican, etc.)	- 1	4. Race - Ame Black, Whit	
s afte or It	by Fu	1 Never Married 2 3 Widowed 4 Divo		If Yes, G	2 X N	0		☐ Yes	2 <b>X</b> No	Specify:				Specify:	White
T2 hours af				Year or Education	Dates:		16a. Deced	ent's Usi	al Occup	ation			16h Kin	nd of Business	Industry
n 72 an r	Completed	(Specify only h	ighest gi	rade completed		,	(Give	kind of wi	ork done d	during mos	t of workin	g	100.74	14 01 040111034	modelly
The second	E O	Elementary/Secondary (0- 12	12)	College	(1-4or 5-	+)			Tead	cher				Sch	ool
filed Hygin other	0	17. Father's Name (First, Mic		st)		·				18. Mothe	er's Name	(First, Middle,	Maiden S	Sumame)	
/Iand	To B	Byron E. Mur	naw								Eliz	abeth	L. S	tiemel	ę.
Mary d 2 sho th and h 7 is ma		19a. Informant's Name/Rela	tionship	(Турв, Print)				_						Town, State, 2	Zip Code)
and and and and and and and and and and		Janet L. Ber	Lin	(Sister	)							rstown			
ore,		20a. Method of Disposition 1 ☐ Burial 2 💆 Crema	ion 3 l	□Removal from	n State		lace of Dispo emetery, cren				Nov.	4,		cation - City or	
Pag ment ant:		4 Donation 5 Oth				Smi	thsbur	-			200		_	thsburg	
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked eny injury or other traumatic e-		21. Signature of Funeral Ser	vice Lice	ensee	če	Mola				ss of Facility Fune:	•			Bradbur burg,Mo	cy Ave. 1. 21783
		23a. Part1. Enter the diseas shock, or heart failure.	e, or cor	mplications that	caused	the death								J.	Approximate Interval Between
Physician		Immediate Cause (Final	LIST ONL	A .i	bach iiin	B.	2	1.							Onset and Death
/Medical		disease or condition resulting in death)		a. /Nu /?; Due to	o (or as a	consequ	y 2 3 / uence of):	( 0	· CC	-					7 Yeirs
Examiner			- 1	h											
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ficate be exectited physicien and sthe burial-transit	Ω Ξ	resulting in death) cast	- 8	Due to	o (or as a	ı consequ	uence of):								
cate be exphysicien the burial	dlcal			d											
A ding	1 40 1	IF FEMALE:		23c. If yes, o	utcome o	of pregna	ncv							2d Data of da	
COIGS, P.O. BOX of wequires that the death certification signed by the attending should be detached for use as	Physician/M	23b. Was decedent pregnan in the past 12 months?	t	1 Live	birth 2	2 Fetal	death 3	Ectopic p	regnancy				-	3d. Date of del Month	Day Year
the d	iysl	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		9Ū Unk				, 0							
Ords, P.	by Pr	Part II. Other significant cor	nditions	contributing to	death bu	t not resu	ulting in the ur	nderlying	cause giv	en in Part I		23e. Did t	obacco us	se contribute to	the cause of death?
auires n sign												10	Yes 2	3No 3□Pi	robably 4 Unknown
KECOTO  he law requir  he has been si  nge 2 should b	Completed											24a. Was		24b. Were at	utopsy findings available
The lav	mo											autor perfo	rmed?	death?	completion of cause of
	0	25. Was case referred to me	dical							26. Place	of Death	(Check only o			20110
OT V Physic this ce	To B	examiner? 1 ☐ Yes 2 ☑ No		Hospital: 1	Inpatier	nt 2 🗆	ER/Outpatien	t_3 D	OA Oth	er: 4□ Nu	rsing Hom	ie 5 ⊡ Kesi	dence 6	Other (Spe	cify)
On On Oil ding Ph. After thi funeral		27. Manner of Death 1 ☑ Natural 5 ☑ Po	endina	28a. Date		y	28b. Time of Injury		28c. Injun Worl	y at k?	2	8d. Describe			
SIO teath. tor: A	catio	2 Accident in	vestigati ould not					М	1 🗆	Yes 2□					
DIVISION If or Attending after death. I Director: Afte	Certification:	3 ☐ Suicide 6 ☐ C 4 ☐ Homicide	termine	d 200. Flat	ce of Inju ding, etc	ry - At ho . (Specify	ome, farm, str /)	eet, facto	y, office		2	8f. Location ( City or To	Street and wn, State)	d Number or Ri	ural Route Number.
Dital ours a sral Dilled is		000 0-4		<u> </u>		· - '	. 1 . 1								
UNISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical			Physician: To the aminer: On the and ma		examinat									s stated. e to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of ce	rtifier					29	c. Licens	e number			29d. Date	e signed (Mont	h, Day, Year)
F 3 F 8		1 Dru	her.	11,00	141	in			04	1666	)		(	1 - 3 - 1	06
h		30. Name and address of pe		o co pleted car	use of de	ath (Item	23a) (Type	Print)	~	-					
d		M. cheel		"lorm.	c/c	,	11110	N	edica	16	Lun	01 /	A.c.	no tou	n mo
Sta	ate	31. Date filed (Month, Day,	(ear)	32.	Pegistra	r's Signa	ture	2.0			J.		7		
Regist	rar	NOV 1	3 2	006	PALLE	a de	F A	Belle	9					noton	

			1 - For State Registrar	State of Mary		artment of F		d Mental Hy	giene Reg. No.	006	35830
	- · · ·		1. Decedent's Name (First, Middle, Last)					2. Date of De	ath Day	Year	3. Time of Death
	Physici /Medio		Esther Virgin	ia Myers						006	7:44 a. M
	Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location of De	eath	4c. C	ounty of Death	
			Garrett County M				land	(		Garre	
	Funeral		5. Social Security Number 6. Sex	14 ONE	yrs. last birthday)	If Under 1 Year Months Days		lin. (Month, Da	y, Year)	Coul	
	Director		233-34-5529 Usual Residence of Decedent		33 Yrs.			Sept.	3,192	3 Neth	nken, WV
	yland yland		10a. State 10b. County	10	c. City, Town or Lo	ocation		· · · · · · · · · · · · · · · · · · ·		1	10d. Inside City Limits
	Mar Hiller	tor	MD Garret	t	Kitzmi	11er					1 X Yes 2 □ No
	filed within 72 hours after death with the Maryland Hygiene. Niter than "naturel", or Items 23a or 28e-f show ent, the Medical Examiner must be notified at	Director	10e. Street and Number			10f. Zip Code			10g. Citize	on of What Cou	ntry?
	23a	rai	612 Third Street			21	538			USA	
	er de	Funerai		<ol><li>Was Decedent Ever Armed Forces?</li></ol>		Was Decedent of H If Yes, specify Cuba	lispanic Origin? an, Mexican, Pu	(Specify Yes or No lerto Rican, etc.)	- 14	<ul> <li>Race - Americ Black, White,</li> </ul>	
99	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:		s	pecify: T.TL	4 = 0
8	hour turel	edb	15. Decedent's Educ		16a Dece	dent's Usual Occup	ation		16h Kind	WI of Business/In	nite
T. TÇ	in 72	Completed	(Specify only highest grade	completed)	(Give	kind of work done DO NOT use retired	during most of	working	100. Kill	I OI DUSINGSS/III	dustry
27	d with giene.	шо	Elementary/Secondary (0-12)	College (1-4or 5+)	Нс	memaker			Own	Home	
פ	othe vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's N	Name (First, Middle			
<u>a</u>	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "naturel; or liems 23a or 28e-f show eumatic event, the Medical Examiner must be notified at	To	George Thomas				Emma	Hickey			
<u>~</u>	s 1 and 2 should f Health and Men flem 27 is marke other treumatic		19a. Informant's Name/Relationship (Typ	ne, Print)	19b. Maili	ng Address (Street	and Number or	Rural Route Numb	er, City or 1	Town, State, Zip	Code)
_	and ealth m 27 her tr		George L. Myers/			Box 30.	5 Kitzı	miller, M			
<b>=</b>			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re		Ob. Place of Dispo cemetery, crei	sition (Name of matory or other plac	Oct	Date 27	20c. Loca	ation - City or To	own, State
Ē	permit. Page Department of Important: If any injury or once.		' 4 ☐ Donation 5 ☐ Other (Specify)			ın_Cemete		006	Bur1	ington,	WV
Ba	Depar Depar Impor any in		21. Signature of Funeral Service License	el il		2. Name and Addre		Smith Fu	neral	Home	
	40200		23a. Part1. Enter the disease, or complic	Ville		85 S. Ma			er, W	V 267	
			shock, or heart failure. List only on temmediate Cause (Final	e cause on each line.	death. Do not en	er the mode of dyir	ig, such as care	nac or respiratory a	rrest,		Approximate tnterval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Atherosc1		ardiovasc	ular Di	sease			years
	Examiner			Due to (or as a co	nsequence of):						
		ē	Sequentially list conditions, b.	Due to (or as a co	nsequanca of).						
58	be exectled sician and burial-transit	Examiner	any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
0	exed an ar an ar rial-tı	Exa	resulting in death) Last	Due to (or as a co	nsequence of):						
8760,	icate be exection physician and strants the burial-tran	dicai	d.						_		
9	artifica ing pl	Med	IF FEMALE:								
Вох	leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	Sc. If yes, outcome of p 1 Live birth 2	Fetal death 3	Ectopic pregnancy	,		23	d. Date of delive Month	ory Day Year
o.	at the de by the a tached f	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant at time 9 ☐ Unknown	of death 5	Other (specify)					24, 1041
٥.	The law requires that the death certifite has been signed by the attending to bege 2 should be detached for use as	Ph	Part II. Other significant conditions conf	ributing to death but no	ot resulting in the u	ndertving cause giv	en in Part I	23e. Did t	obacco use	contribute to the	ne cause of death?
Records,	uires that signed to d be det	Completed by	Metastatic Adenoca		•	, , , , , , , ,					ably 4XUnknown
Ö	w require been sig should b	ete						24a. Was			
e Be	: The law cate has I , page 2 s	dmo						- autor	osy ormed?	death?	psy findings available mpletion of cause of
		e Cc	25. Was case referred to medical				00 01 15	1 □ Yes	28 No	1 🗆 Yes	2□ No
>	ysiclan: is certific director,	0 8	examiner?	ospital:	2 ☑ ER/Outpatier	nt 3□ DOA Oth		Death (Check only of g Home 5 Residual		Other /Specif	
ō	g Phys er this eral di	$\vdash$	27. Manner of Death	28a. Date of Injury (Month, Day Ye				28d. Describe			y)
Ö	ttanding f death. ctor: After / the funer	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(World, Day 16	ar) Intury		Yes 2 □ No				
Division of	r Atta er de recto by th	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, str	eet, factory, office		28f. Location (; City or Tox	Street and I	Vumber or Rura	I Route Number,
	To the Hospitel or Attending Physicien: within 24 hours alter death To the Funerel Director: After this certifica completely filled in by the funeral director,	Certification:		3, 000. (0	//			5, 57.101	, , , , , , , , , , , , , , , , , , , ,		
	d hou t hou uner uner	cal	29a. Certifier 1 Certifying Physical (Check only 2 Medical Examin	ician: To the best of mer: On the basis of exa	y knowledge, death	n occurred at the tir	ne, date and pla	ace, and due to the	cause(s) ar	nd manner as st	tated.
	To the Hos within 24 h To the Fun completely	Medical	one,	and manner stated.	2. 2.19 01 111						
	To with	<	29b. Signature and title of the flier			29c. Licens	e number			signed (Month,	Day, Year)
	2	,				D0023	979		10/3	1/2006	
	Z			npleted cause of death			0.11	1 200 (	1550		
	Sta	to	Robert A. Goralski 31. Date filed (Month, Day, Year)	, M.D. 31	Signature	th Street	Uakla	ind, MD 2	21550		
	Registr		NOV 1 3 200	NA	So for	and of					

			1 - For State Registrar	State of Mary		rtificate of l		-	Reg. No. 0 0	16 35831
			1. Decedent's Name (First, Middle, Las	st)				2. Date of De		3. Time of Death
	Physici		Colonel H. M	larra.				Month	,	Year
	/Medic		4a. Facility Name (If not institution, give	layo		4b. City, Town, or	r Location of Dogs	Octobe	2r 31,20	
	Examin	ier								
			Southern Maryl			Cl	inton		_Prince	e Georges
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In ISXIM 2□ F	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th y, Year)	Birthplace (State or Foreign Country)
	Director		226-28-5709	Am 201	82 Yrs.			May 15	,1924	VA
	P		Usual Residence of Decedent	140	0. 7					The state of the s
	hoy i	_	10a. State 10b. County	100	c. City, Town or Lo	ocation				10d. Inside City Limits
	M -1-	5	DC		Washir	ngton				1 XYes 2 No
	hours after death with the Maryland turel; or Iteme 23a or 28e-f ehow al Experiment be notified at	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wi	hat Country?
	38 G	<u>=</u>	1626 16th Stre	at SF		2002	20		Unitod	l States
	Tie 2	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S. 13.	Was Decedent of H	lispanic Origin? (5	Specify Yes or No		· American Indian,
	Ter in the contract of the con	Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔀 No		If Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.)	Black	x, White, etc.
2	S	by	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify:	D11-
5-0036	72 hours naturel', dicel Erre	be	15. Decedent's Ed	1	16a Doco	dent's Usual Occup	ation		16b, Kind of Bus	Black
Ċ	within 72 ene. then "na!	Completed	(Specify only highest gra		(Give	kind of work done of DO NOT use retired	during most of wo	rking	TOD, KING OF BUS	silies syllidustry
212	P P P	m	Elementary/Secondary (0-12)	Cotlege (1-4or 5+)						
	filed v Hygie Sther t	ပိ	6		Cc	onstruct		(F)	Priva	
2		Be	17. Father's Name (First, Middle, Last)	)			18. Mother's Na	me ( <i>First, Middl</i> e,	Maiden Sumame	9)
<u>=</u>		ဥ	Oley Mayo				Emma	Unknow	n	
Maryland			19a. Informant's Name/Relationship (	Type, Print)	19b. Maili	ng Address (Street	and Number or R	ural Route Numbe	er, City or Town, S	State, Zip Code)
	end 2 ealth a n 27 le ner tra		Douglas L. May	o/son	พอโอ	3 Hess dorf, Md	Court	1		
<u>ā</u>	ーエッコ		20a. Method of Disposition		Ob. Place of Dispo	osition (Name of		Date	20c. Location - C	City or Town, State
Baltimore,	00		1 Burial 2 Cremation 3		•	matory or other plac	1	1/05	-1.	
Ξ			4 □Donation 5 □ Other (Specif			ction Ce			Clinton	
20	permit. Departi Importa any nj		21. Signature of Funeral Service Licer	nsee		2. Name and Addres		_		rds F.H.
_	<u> </u>		Januce E	aurion	ノ 39	910 Silv	er Hil	l Rd.,	Suitlan	nd, Md. 20746
			23a. Party Enter the disease, or com shock, or heart failure. List only	plications that caused the	death. Do no ent	ter the mode of dyin	og euch ae cardia	c or respiratory a	rrest	Approximate
Ц.,			·			,	ig, such as cardia	o or roophatory a	11031,	Interval Between
	THE PARTY OF THE P		Immediate Cause (Final		Dr	•	A			Interval Between Onset and Death
*	Physician /Medical		disease or condition resulting in death)	a	Pr	•	A			
*	/Medical Examiner		disease or condition	aDue to (or as a con	nsequence of):	•	A			
*	/Medical	,	disease or condition resulting in death)  Sequentially list conditions.	b. Chro	insequence of):	•	A			
	/Medical Examiner	ilner	disease or condition resulting in death)  Sequentially list conditions, Tany, teaming to ammodiate cause. Enter Underlying	b. Due to (or as a co	insequence of):	•	A			
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	ath certificate be executed  Medical by executed and missing physicien and or use as the burial-transit	dical Examin	disease or condition resulting in death)  Sequentially list conditions, I any, learning to annealizate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	b. Due to (or as a cold d. 23c. If yes, outcome of print of the cold but the cold b	regnancy	BS TO	cuctin		mays	Onset and Death
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			1- For State of Maryland Registrar		artment rtificate			nd M		giene ()	06	35832
	Physici /Medi	al	Decedent's Name (First, Middle, Last)     FREDERICK JAMES MCCALL      4a. Facility Name (If not institution, give street and number)	SR.		Town or	Location of		2. Date of Dea Month NOVEMB	ER 1	2006 by of Death	3. Time of Death 7:55a M
	Examir	ier	109 Essex Rd.	4 Link 4 . 1		ste	rtowr	n		Que	en Ar	nne's
	Funeral Director		5. Social Security Number  059-24-9274  Usual Residence of Decedent  6. Sex  7. Age (In yrs. Ias	Yrs.	Months	Days		Min.	8. Date of Birt (Month, Date May 7	1930	Cour	place (State or Foreign htry) VYOTK
	e Maryland Ba-f show	ctor	10a. State 10b. County 10c. City, 1 MD Queen Anne's Che		cation town						1	1
	h with th	al Dire	10e. Street and Number 109 Essex Rd.		10f. Zip 21	620				10g. Citizen of U . S . A		ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, the Medical Exeminan must be notified at Once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Deceded Yes, spec		spanic Origin, Mexican, Specify:	in? (Spe Puerto f	cify Yes or No- Rican, etc.)	14. Ra Bla Speci	ce · Americack, White,	
21215-0036	i within 72 ho liene. r than "natur the Medical I	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give life.	DO NOT us	k done di e retired)	uring most o		•	16b. Kind of I		
Maryland 2	ould be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last) Frank McCall				Mary	/ E	(First, Middle, Lizabe	Maiden Suma th Fu	me) gazzi	
	1 and 2 sho Health and tem 27 is m		Catherine McCall (wife)	P.O.	Box Box esition (Naminatory or oti	66	6 Ch	nest	Route Numbe		. 216	520
Baltimore,	permit. Pages Department of Important: If It any injury or o		2 Cremation 3 Bremoval non State	ena	Ceme	ter	y   1		6/06	Gale:	na, N	
	×2 1 -		23a Part. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cluse on such line.	10 1	<u> 18 W</u>	<u>est</u>	Cros	ss S	St. Ga	lena,	MD.	21635 Approximate Interval Between Opeet and Death
	Pnysician /Medical Examiner		disease or condition resulting in death)  a. Due to (or as a consequent	ate of):	_duc		Ca	( u	br	-cas (		Syrs
8760,	cate be exequted physician and the burial-transit	Ical Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events resulting in death) Last  b. Due to (or as a consequence) to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total									
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of	o o	atlon, To B	examiner?  1   Yes 2   No   Hospital: 1   Inpatient 2   ER	VOutpatien 3b. Time of Injury	t 3 DOA	Other c. Injury Work	. 4 🗆 Nursi	ing Hom	Resid	ence 6 □Ot		()
Division	Diffe	Certificationy	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)						City or Tow	n, State)		l Route Number,
	To the Hospital within 24 hours a To the Funeral i completely filled	Medical	29a. Certifier Check only one)  2 Medical Examiner: On the best of my knowle (Check only one)  2 Medical Examiner: On the basis of examination one)  29b. Signature and title of certifier	edge, death n and/or inv	estigation,	t the time in my opi License	nion, death	place, a occurre	d at the time, d	ause(s) and m date and place, 29d. Date signs	and due to	the cause(s)
	(-		30. Name and address of person who completed cause of death (Item 23	<b>→</b>	> -/	5/	64	8	3	///	1	06
	Sta	te	Wayne D. Benjamin, M.D. 6	602	Chur		Hi11	Rd.	Ches	terto	wn, N	ID. 21620
	Registi		NOV 1 3 2006 32. Registrar's Signature	To for	ASAGE-	90						ph. minute.

State of Maryland / Department of Health and Mental Hygiens, For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** CATHERINE ALICE MONTAGUE NOVEMBER 4 2006 2:50p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Chestertown Nursing & Rehab Chestertown Kent If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days 1 ☐ M 2/2 F Yrs Director 87 221-16-9179 Feb 18 1919 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-1 show any injury or other treumatic event, the Medical Exercity of the Indifficultations. Once. 10a State 10c. City. Town or Location 10h County 10d. Inside City Limits X Yes 2 No Director MD Kent Galena 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 107 West Cross Apt. St. 21635 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₹ No Specify: Completed by Specify: 3X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Chemical Elementary/Secondary (0-12) College (1-4or 5+) Manufacturer Collating Operator 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alex Powell Sara Newnam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adelaide Ernest (sister) P.O. Box 580 Cecilton, MD. 21913 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐Donation 5 ☐ Other (Specify) Galena Cemetery 11/8/06 Galena, MD. 21. Signature of Funeral Service Licenses Galena Funeral Home of Stephen L. Schaech 118 West Cross St. Galena, MD. M00510 21635 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause/(Final Respiratory **Physician** 7 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Pheumon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine PS that initiated events resulting in death) Last The law requires that the death certificate be exect Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical as the b attending IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? þ Sovere Poripheral 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Dencentia 2 🗆 No 1 Yes 2 No 1 Yes Hospitel or Attending Physicien: Be 25. Was case reterred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After Injury М 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 06 D 5099L 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neil Stoddard, M.D. 100 Brown St. Chestertown, 21620 MD. 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar 2006

		í	For State Registrar	State of Maryland	Cei	rtificate of L	Death	nd Mental H	ygiene Reg. No.	006	35834
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	Physici: /Medic		DEBORAH ANN	MEDINA				OCTO:	BER 2	7,2006	8:30AM <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give	·		4b. City, Town, or	Location of	Death	4c. C	County of Death	
- 2			4083 CROWBILL ( 5. Social Security Number 6. Se		a thinth day	WALDOR If Under 1 Year	<b>F</b> If Under 24	1 Hrs   0 D-1/ F		CHARLI	
34.	Funeral Director			7. Age (In yrs. la	Yrs.	Months Days	Hours	Min. (Month, L	Day, Year)	Cou	place (State or Foreign untry)
	0.000		Usual Residence of Decedent	40				OCT . L	2,195	8 NEW	YORK
	show	_	10a. State 10b. County	10c. City	, Town or Lo	ocation					10d. Inside City Limits
	8a-f	Directo	MARYLAND CHARI	LES WA	LDORE						1 Yes 2 XNo
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	leath	Funeral	4083 CROWBILL (	COURT  12. Was Decedent Ever in U.S	5. 13	206 Was Decedent of Hi	0.3	n? (Specify Yes or N	U U	S A 4. Race - Amer	ican Indian
SO.	or then	핊	1 ☐ Never Married 200 Married	Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give	1			n? (Specify Yes or N Puerto Rican, etc.)		Black, White	, etc.
ğ	ours a	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give ** Year or Dates:		1 ☐ Yes 2XX No	Specify:		S	Specify: WI	HITE
<u>2</u>	within 72 hours after death with the Maryland ene. then "naturel", or items 23s or 28s-f show ca Madical Examiner must be notified at	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occupa	lurina most c	of working	16b. Kind	d of Business/Ir	ndustry
12	withir ene. then	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired,	,				
2	filed Hygid other ant, II	ပိ	1.7. Father's Name (First, Middle, Last)		— HC	MEMAKER	18. Mother's	s Name (First, Midd		OWN HO	)ME
<u>a</u>	should be nd Mental marked o	To Be	WILLIAM A. BES	SCHER			DOLO	DES E	MONZ		
Maryland 21215-0036	should and Men s marks urmatic	-	19a. Informant's Name/Relationship (T		19b. Mailir	ng Address (Street a		or Rural Route Num			ip Code)
Σ	s 1 end 2 should be filed within 72 hours after death with the Marylan if Heath and Mental Hygiene. Item 27 Is marked other then "naturel", or iteme 23e or 28e-f show other traumatic event, the Madical Examiner must be notified at		MIQUEL MEDINA,	JRHUSBAND	4083	CROWBI:	LL CT	.,WALDO	RF,MA	ARYLAN	ND 20603
altimore,	permit. Pages 1 en Department of Heal Important: If itam 2 eny injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I	1 00	ace of Dispo metery, crei	osition (Name of matory or other place	9)	Date	20c. Loca	ation - City or T	own, State
Ē	Pages tment of I tant: If its jury or or		4 □ Donation S □ Other (Specify,	) METROPO				10-31-0	6 ALE	XANDRI	IA, VA
Ba	permit. Departm Imports eny inju		21. Signature of Puneral Service Licens	MOO.	4700 27 R	2. Name and Address AYMOND	s of Facility FUNER	AL SERV	ICE.	P.A.	
	46244		23a. Part1. Enter the disease, or comp	dications that caused the death							Anarovimoto
	<u> </u>		shock, or heart failure. List only o	one cause on each line.							Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Myelod Due to for as a consequ	920	lastic	250	Marsh	و		
					14		/1				
	Examiner			Due to (or as a consequ	ende of):		0				
	***	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying	b. Due to (or as a consequ			0				
	***	aminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequence.	ence of):		0				
20,	***	i Examiner	Cause (Disease or injury	b	ence of):		0				
,0928	***	licai	that initiated events	b. Due to (or as a consequence.	ence of):		0				
9	***	licai	Cause (Disease or injury that infittated events resulting in death) Last	b. Due to (or as a consequing consequing document).	ence of):		0				
Box 6	***	licai	Lause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	b. Due to (or as a consequence.	ence of): ence of): ence of):	⊒Ectopic pregnancy	0			3d. Date of deliv	very Day Year
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	1 - State of Maryland / Department of Health and Me  Certificate of Death	ental Hygiene 2006 35835
Physician /Medical Examiner	GEORGE EDWARD MILLS, JR.	2. Date of Death Month Day Year 3. Time of Death 1930 M 4c. County of Death
, Funeral	5. Social Security Number  6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. a Months Days Hours Min.	Date of Binth (Month, Day, Year)  9. Binthplace (State or Foreign Country)
Director	229-48-6994	UG. 25, 1938 VIRGINIA
with the Mary s or 28a-1 eh be notified	MARYLAND ST. MARY'S MECHANICSVILLE  10e. Street and Number 10f. Zip Code	1 ☐ Yes 2 [XNo
036 us after death v ii, or itema 23 can be must	29641 DOGWOOD CIRCLE  20659  11. Marital Status  1 Never Married  3 Widowed 4 Divorced  20659  12. Was Decedent Ever in U.S. Amed Forces?  1 Never Married  3 Widowed 4 Divorced  1 Ves 2 No Specify:  1 Yes 2 No Specify:	fly Yes or Nocan, etc.)  14. Race - American Indian, Black, White, etc.  Specify: WHITE
21215-0036 ed within 72 hours all ygiene per then "naturel", or it, the Medical Exami Completed by F	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  11  College (1-4or 5+)  SHEET METAL SUPERVISO	
Maryland 2 dd 2 should be filed the and Mental Hygi the and Mental Hygi the and short traumatic event, To Be Co	17. Father's Name (First, Middle, Last)  GEORGE EDWARD MILLS, SR.  THELMA	First, Middle, Maiden Surname)  ALSOP
Baltimore, Maryla permit. Pages 1 and 2 should to Department of Health and Ment important: If Item 27 is marken eny injury or other traumatics once.	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Information (Type) (Ty	E, MECHANICSVILLE, MD20659  20c. Location - City or Town, State  -2-06 WALDORF, MARYLAND
bhysician and physician and the burial-transit the burial-transit close Examiner		Interval Between
, P.O. Box 6876( that the death certificate be led by the attending physicia detached for use as the bu	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	23d. Date of delivery Month Day Year
So gane es t	Part II. Other significant continuous contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown
The law ate hes b page 2 st		24a. Was an autopsy performed?  1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No
ding After fune	examiner? 1 Tes 2 No  Hospital: 1 npatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	Check only one)  5 □ Residence 6 □Other (Specify)  d. Describe how injury occurred Fell Ini  do 10/5 □ Fell Ini
Division its of the control of the c		City or Town, State) See Leonard Town
To the Hospital of Within 24 hours ald To the Funeral D completely filled in Medical Cel	29a. Certifier   Certifier   Certifier   Certifier   Check curry   Check	d due to the cause(s) and mainer as stat at the time, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
σ	30. Name and address of person who impleted cause of death (Item 23a) (Type, Print)	Coto ber 31, 2006 Fel. Upper Mariboro, Mb. 2077
State Registrar	31. Date filed (Mogth, Day, Year)  32. Abgistrar's Signature	Rol. Upper Mallboro, Mb. 2077:

			1 - For State Registrar	State of Mary		epartment of F Certificate of			2006	35836
¥	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		ELMER 4a. Facility Name (If not institution, give	BENNETT NAGY		4b. City, Town, o	r Location of Death	october .	23 200 4c County of Dea	œ o
7			5. Social Security Number 6. S.	ax 7. Age (In	yrs. last birth	LQ Y	OHQ If Under 24 Hrs.	8. Date of Birth	chai	thplace (State or Foreign
	Funeral Director		103-20-4207	7. Age (In		rs. Months Days	Hours Min.	JULY 10,	1934 PEN	NSYLVANIA
	yland		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town	or Location				10d. Inside City Limits
	he Mar 28a-f e	Director	MARYLAND CHARLE	S		WALDORF		40-	0	1 Yes 2 No
	h with 1		1072 DORSET DRIVE			10f. Zip Code	602		. Citizen of What C UNITED ST	•
	within 72 hours after deeth with the Maryland ene. than "natural", or items 23a or 28a-f ehow ha Madical Examinar musi Le notified al	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ XMarried	12. Was Decedent Ever Armed Forces? 1X Yes 2 □ No	in U.S.	13. Was Decedent of h If Yes, specify Cub	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
5-0036	ours aff	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1956	1 ☐ Yes 2X No	Specify:		Specify:	WHITE
15-0	in 72 h n "natu ledical	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		Decedent's Usual Occup Give kind of work done life. DO NOT use retire	durina most of worki	ing 16	b. Kind of Business	Vindustry
2121	ed with ygiene. ner thai	Com	Elementary/Secondary (0-12)	College (1-4or 5+)	I	ISTRIBUTIO			POSTAL SE	ERVICE
Maryfand	ld be fil ental H ked ott ic even	To Be	17. Father's Name (First, Middle, Last) BENJAMIN NAGY					e (First, Middle, Ma BENNETT	iden Sumame)	
ary	2 shou and M is mar surnat	-	19a. Informant's Name/Relationship (1	**		Mailing Address (Street		,	, , ,	F /
	1 and Heelth em 27 ther tr		MARY JANE NAGY - 1  20a. Method of Disposition		0b. Place of	2 DORSET DI			YLAND 206 c. Location - City or	
Baltimore,	Pages nent of int: if it iry or o		1 ØBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery	crematory or other place MEM. GDNS	00101	BER	WALDORF,	
Balt	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural; or items 23a or 28a-f ehow emportant: if item 27 is marked other than "natural; or items 23a or 28a-f ehow empty injury or other traumatic event; it is Maralcal Examinat must be notified at once.		21. Signature of Funeral Service Signature	son MOOD	53	P.O.BOX 1	ss of Facility HI	JNTT FUNE		30604 DORF, MD
h			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the	death. Do n	ot enter the mode of dyir	ng, such as cardiac o	or respiratory arrest	,	Approximate Interval Between Onset and Death
H	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a co	nsequence o	Myocons	in en	restro	7	60 minutes
ı	Examiner		Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	rono		my de	sisse		10 years
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Due 10 (01 as a co	i isequerice o	<i>y</i> . (	1			^
68760,	ficate be executed physicien and s the burial-transit	edical Exa	resulting in death) Last	Due to (or as a co	nsequence o	f):				
_			IF FEMALE:	23c. If yes, outcome of pr	regnancy					
P.O. Box	The law requires thet the death centifule has been signed by the attending agge 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death	3 Ectopic pregnancy 5 Other (specify)			23d. Date of de Month	Day Year
	w requires that been signed b should be deta	by	Part If, Other significant conditions o	ontributing to death but no	ot resulting in	the underlying cause give	ren in Part I.		cco use contribute t	o the cause of death?
Division of Vital Records,	The law resete has be page 2 sho	Completed						24a. Was an autopsy performe	d? prior to death?	utopsy findings available completion of cause of
Vita	sician: Th certificete irector, pag	Be	25. Was case referred to medicat examiner? 1 XYes 2 □ No	Hospital: 1 ☐ Inpatient	a [] [D/O	nations ald DOA Oth	er	(Check only one)	a E 01 - 10	
n of	Attending Physician: or death. ector: After this certifice by the funeral director, I	on: To	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Ye	28b. T		v at	28d. Describe how	e 6 □Other (Spe injury occurred	eciny)
isio	or Attendi after death. Director: A in by the fu	Certification:	2 Accident Investigation 3 Suicide 6 Could not be		At home, far	M 1	Yes 2 No	28f. Location (Stree	et and Number or R	ural Route Number,
á	ital or A		4   Homolde	building, etc. (S	pecify)			City or Town, S		
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funerel Director: After this certificate h completely filled in by the funeral director, page	edicai	29a. Certifier 1 <sup>th</sup> Certifying Ph (Check only 2 Medical Exan one)	ysicien: To the best of m niner: On the basis of exa and manner stated.	y knowledge, imination and	death occurred at the till for investigation, in my o	ne, date and place, ppinion, death occurr	and due to the caused at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1 Perhant	0 22	29c. Licens	e number	290	Date signed (Mon	th, Day, Year)
(			30. Name and address of person who	completed cause of death	(Item 23a) C	Type, Print)	178/4	C	clobera	7,2006
	BREIL		Gerald	Apollon 1	N.D.	- 4	a Plota	medic MD 21	0646	161-
100	Sta Registi		31. Date filed (Month, Day, Year)  OCT 2 6	32. Raistrar's :	Signature	Sociale)	l			

			1 - For State Registrar	State of M	arylar	nd / Depa	artment rtificate	of He	ealth an Death	d M		gien Reg. N		6	35	837
3	Physic /Medi		1. Decedent's Name (First, Middle, La Gwennie	Le	e	0	sborne				2. Date of De. Month Octobe	ath		 06	3. Time o	
	Exami	ner	4a. Facility Name (If not institution, gir Clinton Nursing & 5. Social Security Number 6.	Rehab. Center		loss birth 1	Clin	ton	ocation of D			F	c. County of Prince (	Death Corp		
Ú,	Funeral Director		219-12-3037 Usual Residence of Decedent	1 M 200xF	85	last birthday) Yrs.	Months E	ays	Hours !	vlin.	8. Date of Birt (Month, Da June 21,	y, Year	21	Birthpl Coun	ace (State try) Georgia	or Foreign 3
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or items 23s or 28s-f show its Michel Examinating the motified at	sted by Funeral Director	10a. State 10b. County  Maryland Prince G  10e. Street and Number  6700 Livingston Road  11. Marital Status  1 Never Married 2 Married  3 Marylowed 4 Divorced  15. Decedent's E	12. Was Decedent Armed Forces? 1 □ Yes 2 📆 II Yes, Give Year or Dates:	Ever in U.	16a. Deced	Hill  10f. Zip Cc  20  Vas Deceden f Yes, specify  I Yes 250  Jent's Usual O	745 t of Hisp Cuban,	Specify:		ify Yes or No- ican, etc.)	US	A  14. Race - , Black, \ Specify:  Sind of Busin	America Vhite, e	in Indian, tc. White	City Limits
	permit. Pages 1 and 2 should be filed within 72 hours al Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or any follury or other traumatic event, the Macical Exampage.	o Be Completed	(Specify only highest grant property only highest grant property for the secondary (0-12) 12  17. Father's Name (First, Middle, Last Jacob James Joi	College (1-4or 5	+)	life. L	kind of work of DO NOT use n memaker	etired)	8. Mother's I	Name (	First, Middle.		In	Home	,	
, Maryland	and 2 shoul saith and Me n 27 is mark	To	19a. Informant's Name/Relationship ( Sharon O. Osborne / I	Type, Print)		19b. Mailin 4409 B	g Address (Si erwick I	reet and	Mabe Number or Woodbi	Rura/	Gibson Route Number Virgin	r, City o	or Town, Sta. 22192	te, Zip (	Code)	
Baltimore,	it. Pages 1 ritment of Hi riant: If Iter njury or oth		20a. Method of Disposition  **Disposition 3	y)	C	lace of Disposementery, crem Rest Ce	natory or other metery	r place)	10/3		006	Lal	ocation - City Plata, 1	hrv]	and	
Ba	Depa Impo any ir		21. Signature of Fupera Service Licer  23a. Part1. Enter the disease, or com shock, or heart failure. List only	1	the death	6	160 Oxor	Hil	1 Road	Oxor	ge P. Ka Hill, N	hry.		20745		
58760,	Physician bulled in the price of the price of the physician and bulled in the price of the physician street in the price of the physician street in the price of the physician street in the physician	dical Examiner	shock, or heart failure. List only temediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertyping Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a Due to (or as a d.	consequ	Cardinate of):  Cardinate of):  Tib									nterval Bety Onset and C	ween Death
. Box (	death certiff e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2XXNo 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	Fetal	death 3 □E	Ectopic pregna Other (specify					2	23d. Date of Month			'ear
	igned be de	þ	Part tt, Other significant conditions of	ontributing to death bu	not resul	iting in the und	derlying cause	grven in	n Part I.	-			se contribute			
		e Completed	25. Was case referred to medical							-	24a. Was ar autopsy perform 1 Yes 2	red?	24b. Were prior to death	o comp ?	y findings a letion of ca	ivailable luse of
n or	ing Phy Mer this Ineral di	ToB	examiner?  1 Yes 2 XMo  27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	Hospital: 1 Inpatien  28a. Date of Injury (Month, Day)  28e. Place of Injury	Year)	R/Outpatient 28b. Time of Injury	28c. I	Other: njury at Work?		Home 28d	5 Reside	nce 6 w injury	occurred			
5	± 5 0 0 €	cal Cert	29a. Certifier 120 Certifying Phy	28e. Place of tnjur building, etc.	my know	ladge death	and at the	- time -	date and place		Location (Str City or Town, due to the ca	, State)				
)	To the Hos within 24 h		29b. Signature and title of certifier	and manner state	od.		29c. Lice	у оринс	mber	curred a	at the time, da	te and	place, and do signed (Mo	nth, Da	e cause(s)	
	(6)		30. Name and address of person who c Khosrow Davachi 31. Date filed (Month, Day, Year)	MD 7801 0	old Br	anch Ave	nue #40	09 (	Clinton	, Mai	ryland 2	2073	5			
	Stat Registra	_	OCT 2 6 2006	82. Registrar	J.	bout										

			1 - For State Registrar	State of	Marylar				ealth a	and M	ental Hyg	giene	006	35838
Н	Physicia	an	Decedent's Name (First, Middle     T =	_	**			~ ! vv			2. Date of Dea Month October		2 Year	3. Time of Death
	/Medic	al		eah	Huser			O'Har		(5	October	<del>-</del>	2006	5:27 A.M
1	Examin	er	4a. Facility Name (If not institution National Naval					thesd	Location o	of Death			County of Death	
	Funeral		5. Social Security Number	6. Sex 7		last birthday)	If Unde	r 1 Year	If Under 2		8. Date of Birti (Month, Day	1		place (State or Foreign
	Director		NONE	1□M 2□F	C	Yrs.	Months 0	Days 0	Hours 3	Min. 2	Oct 19,	200	6 Mary	vland
	pu *		Usual Residence of Decedent  10a. State 10b. County		10c Ci	ty, Town or Lo	veation							10d. Inside City Limits
	/anyle	ō		.e										1 ☐ Yes 2 ☐ No
	28e-	rect	Virginia Fair  10e. Street and Number	Lax	Spr	ringfie		p Code		<u> </u>		10g. Citiz	en of What Co	
	ours after death with the Maryland ref, or items 23a or 28e-f show Exertiner frast be rediffied at	Funeral Directo	5300 Easton Dri	.ve				22151				USA		
		ner	11. Marital Status	12. Was Deced	lent Ever in U	J.S. 13.	Was Dece	edent of Hi	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	1.	4. Race - Amer	
36	hours after turel', or ite	by Fu	1 X Never Married 2 Marr	ied 1 ☐ Yes 2 If Yes, Give	2 <b>X</b> X	1	ıı res, spe		Specify:	, 1 4610	riicari, etc.)		Black, White	
21215-0036	72 hours "naturel", dical Exp		3 Widowed 4 Divorced	Year or Dat	tes:	160 Dass	danda Ha						Wn	
7.	in 72 ho "natur	Completed	(Specify only highes	st grade completed)		16a. Dece (Give life.	kind of w	iai Occupa ork done d ise retired	turina most	t of worki	ng	16b. Kin	d of Business/l	ndustry
212	e filed within af Hygiene. I other then " vent, I're Me	E O	Elementary/Secondary (0-12)	College (1-	4or 5+)	Nev	er W	orked	l			Nev	er Work	ted
bu	e file at Hyg I othe vent,	3e C	17. Father's Name (First, Middle,	111.					18. Mothe	r's Name	(First, Middle,	Maiden S	iumame)	
ylaı	Ments Ments arked	To Be	Timothy Paul O'	Hara					Sta	icy J	o Huser	•		
, Maryland	ies 1 and 2 should be filed within of Health and Mental Hygiene. If Item 27 is marked other than " or other treumatic event, It a Men		19a. Informant's Name/Relations Stacy Jo Huser-			19b. Maili 5300	East	s (Street a ton D	nd Number rive,	or or Rura Spr	Route Numberingfiel	r, City or .d <b>,</b> V	Town, State, Z irginia	ip Code) a 22151
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: if Item 27 is eny injury or other tre		20a. Method of Disposition  1  Burial 2 Cremation  4  Donation 5 Other (S)		tate	Place of Dispo cemetery, crea	matory or	other place			ate 2006		ation - City or I	
Balti	permit. Departrimporte eny inju		21. Signature of Funeral Service	Licensee	ar									Virginia eral Care ginia 22044
П			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca	used the deal								OII, VII	Approximate
	Physician		Immediate Cause (Final disease or condition	•	aturit	v								Interval Between Onset and Death
4	/Medical		resulting in death)	_ a.	r as a consec	<del>-</del>								
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	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	ras a consec	quence of):								
	be executed ician and burial-transit	xan	that initiated events resulting in death) Last	c	ras a consec	quence of);								
8760,	ite be execu iysician and ne burial-trai	icai E												
9				0.										
Вох	aath certifica attending ph for use as t	M/UR	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnath 2 □ Feta		]Ectopic p	vaananav			V	23	ld. Date of deliv	very
	Q o G	sicis	in the past 12 months? 1 □ Yes 2 ☑ No		nt at time of c		Other (s						Month	Day Year
P.0	ac Se	Phy	9 Unknown			this is also	- 1 . 1				on- pide	<u> </u>	9	
of Vital Records,	w requires that the been signed by the should be detache	Completed by Physician/Med	Part II. Other significant condition	wis contributing to dea	ith but not res	suring in the u	nderrying	cause give	en in Parti.		1 T	X		the cause of death?
မ ပိ	aw is b	ple									24a. Was a		24b. Were aut	opsy findings available
<u>=</u>	ate T	Con									perfor	med? 2 XNo	death?	ompletion of cause of 2 No
Vit.	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				055		of Death	(Check only or	10)		
of	\$ .⊻ ō	7	1 ☐ Yes 2/2 No 27. Manner of Death	ı FX(ıu)		ER/Outpatier			4 🗆 1901		ne 5 Resid			ify)
0	ding h. After fune	tion	1XX atural 5 ☐ Pendin		Day Year)	Injury	м	28c. Injury Work	:?` /es 2 □ N		.gu. Describe n	ow injury	occurred	
Division	Atten deat ctor: y the	Certification:	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of	of Injury - At h	ome, farm, str					28f. Location (S	treet and	Number or Rui	al Route Number,
οį	after after Dire d in b	erti	4 Homicide determ	building	g, etc. (Specil	fy)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Tow	n, State)		
	To the Hospitel or Attending Ph within 24 hours attended hit System of the Funerel Director: After the completely filled in by the funeral	edical (	29a. Certifier (Check only one)  Certifyin 2 Medical	ng Physician: To the b Examiner: On the bas and manne	sis of examina	owledge, deat ation and/or in	h occurred vestigation	at the tim	e, date and pinion, deat	d place, a	and due to the dead at the time, o	ause(s) a late and p	nd manner as place, and due	stated. to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifie	^ ^	00-		29	c. License	number	Vin	ginici à	9d. Date	signed (Month	Day, Year)
	90		CAmal	Mal,	1/11		(	0101	2380	998	(	201	ober	27, 2006
	(4)		30. Name and address of person		of death (Iter	п 23а) (Туре,	Print)	- 101	Nat	tion	al Nava	1 Med	dical C	enter
	0			nall-Pal	5	401	V.3 K	1/4120	lvc Bet	thes	da, Mar	yland	20889	-5600
	Sta Registr	-	31. Date filed (Month, Day, Year) NOV 02 2006	Geren X	gistrar's Sions	ature								

### 06-07873 Margaret Oufiero

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	to or waryland /		ificate of Dea			Reg No. 20	06 3583					
Physicia Medical Exami		Decedent's Name (First, Middle,	,				2. Date of D Month	Day Year 20, 2006	3. Time of Death 0359 hrs					
- N	1101	Margaret  4a. Facility Name (if not institution,	Oufiero give street and number)		4b. City	, Town, or Location		20, 2006 4c. County of D						
		Route 270 north of Rou	te 370		Roc	kville		Montgomer						
Funeral		5. Social Security Number 6	. Sex 7. Age (	(In yrs. las	t birthday) If Un		. 1	Birth (MM/DD/YYYY) 9	Birthplace (State or reign					
Director			1 M 2XF	26	Yrs	ths Days Hours	s Min. June	23, 1980	Country) VA					
any		Usual Residence of Decedent  10a State 10b. County		Oc. City. To	own or Location				10d Inside City Limits					
* "	L	VA Fairfa		•	fax Statio	on			1 Yes 2 X No					
faryland 28a-f show Latonce	Director	10e Street and Number			10f. Z	ip Code	7	10g. Citizen of What Country						
-0036 d within 72 hours after death with the Maryland giene ther than "natural", or items 23a or 28a-f sho is Medical Examiner must be notified at once.	į	11051 Sandy Man	or Drive		2:	2039		United St	ates					
th with	Funeral	11. Marital Status 1 X Never Married 2 Marr	12. Was Decedent Ev	ver in U.S.	13. Was Dece	dent of Hispanic Ori	gin? (Specify Yes or I	No- 14. Race - Ar White, etc	merican Indian, Black,					
er dear				No		2 X No specify:		Specify: Wh						
hours fter 'natural'', Examiner	d by	15. Decedent's Education (Specif	_ or Dates:	leted) 1	6a. Decedent's Usua		kind of work done	16b Kind of Busine						
6 .72 ho	Completed by	Elementary/Secondary (0-12)	College (1-4 or 5+	)	during most of w	orking life. DO NOT	use retired)		·					
5-0036 It d within 72 It giene I ther than '	d mo	47 Fatharla Nama (First Madd)	4		General			Fitness						
40 ≃ = □	a.	17. Father's Name (First, Middle, Lawrence A. Oufi	•			4	's Name (First, Middle th A. Reza							
2121; 2121; buld be fill Mental bunarked	10 E	19a. Informant's Name/Relationship			umber, City or Town, St	tate, Zip Code)								
MD d 2 shor Ith and n 27 is		Lawrence A. Ouf	ero / Father				Drive, Fa	irfax Stati	on, VA 22039					
Baltimore, MD 2 bernit Pages I and 2 shou bepartment of Health and h mportant: If item 27 is in injury or other traumatic		20a. Method of Disposition  1 Burial 2 X Cremation	3 X Removal from State	20b. Pla cre	ace of Disposition (Na ematory or other place	ame of cemetery, e)	October 2	20c. Location - City	or Town, State					
그 그 의 등 등 등		4 Donation 5 Other Spec	cify:		fax Memor	ial F.H.	2006	Fairfax,	VA					
Balti permit Deparm Import injury		21 Signature of Funeral Service Li	1,	0056	Fairfa	d Address of Facility X Memoria	1 Funeral	Home	20					
Physician	-	21 Signature of Furtral Service Licensee  22 Name and Address of Facility Fairfax Memorial Funeral Home 9902 Braddock Road, Fairfax, VA 22032  23a Part Venter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Integrations of Facility Fairfax Memorial Funeral Home 9902 Braddock Road, Fairfax, VA 22032  Approximate Integrations of Facility Fairfax Memorial Funeral Home 9902 Braddock Road, Fairfax, VA 22032												
/Medical Examiner	1	Immediate Cause (Final disease a Multiple Injuries Death												
		or condition resulting in death)	Due to (or as a consequ	uence of):										
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):										
	if any, leading to immediate cause. Enter Underlying Cause (Ulsius or it jury that it itlend events resulting in death) Last use to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):													
cuted nd iransit		events resulting in death) Last	d											
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	/Medical	UNPENDED	AMENDED											
8760, ificate be g physic s the bur		IF FEMALE: 23b Was decedent pregnant in the	23c. If yes, outcome	of pregnar		n 3 Ectopio	pregnancy	23d Date of deliv	·					
Sox 687 leath certifit e attending for use as t	Physician	past 12 months?	4 Pregnant at tim	ne of death			pregnancy	Monta	Day Year					
D. Box the death c	Ž,	1 Yes 2 No 9 V Unkno	9 UTKNOWII		Miner to the control of									
rres that the signed by	2	Part II. Other significant condition	s contributing to death b	ut not rest	uting in the underlyin	ig cause given in Pa		tobacco use contribute	robably 4 Unknown					
ords, w require s been sig	Completed	•••			<del></del>		24a. Wa		autopsy findings available					
e law re has b	du				·		per	opsy prior t formed? death	o completion of cause of					
tal Rec	ပ္ပ	25. Was case referred to medical				26.Place of Death	(Check only one)	2 No 1	Yes 2 No					
Vita hysicia this cer	OB O	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 E	R/Outpatient 3	DOA Other	Nursing Home 5	Residence 6 🗸 Ot	her. Scene					
Division of Vital Records, has or Attending Physician: The law requirers after death all Director: After this certificate has been sited in by the funeral director; page 2 should the funeral director; page 2 should the funeral director; page 2 should the funeral director; page 2 should the funeral director; page 2 should the funeral director; page 2 should the funeral director; page 2 should the funeral director; page 2 should the funeral director; page 2 should the funeral director; page 2 should the funeral director; page 2 should the funeral director; page 3 should the funeral director and the funeral director	ايّا	27. Manner of Death	28a. Date of Injury (Month, Day Year Oct 20, 2006	28	8b. Time of Injury	28c. Injury at Work	Dassenger	how injury occurred rauto auto collisio						
Sion vitend death ctor:	atio	Natural 5 Pending 2 Accident Investig	ation		1339 hrs	1 Yes 2	NO -							
Divisospital or A hours after interal Directly y filled in b	Certification:	3 Suicide 6 Could r	lot be		e, farm, street, factor	y, office building, etc	or Town,	State)	Rural Route Number, City					
Div Div 124 hours afte e Funeral Dir etely filled in	_	4 Homicide  29a. Certifier 1 Certifying Phys	sician: To the best of my ki			ne time, date and pla		north of Route 37						
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medica		ner: On the basis of examinand manner stated.											
- 10	M	29b. Signature and title of certifier			29	c. License number		29d Date signed (1	Month, Day, Year)					
PO		Hamile Youthall.	NA			O.C.M.E.		October 20, 20	06					
		<ol> <li>Name and address of person who Pamela E. Southall, MD</li> </ol>			,	Street Baltim	ore, MD 21201							
St	ate	24 Date filed (Marks Da Ward	Registrar's	Signature		- Jacob, Baldin								
Regist	rar	061234	Blown	J.J.	HOWEL									

### 06-08067

### Please Type or Print in Black Indelible Ink

Jamie M. Osbur	n, J		tment of Health and		000		
		1- For State Certi	ificate of Death		Reg. No. 2006	3584	
Physici Medical Exami		1. Decedent's Name (First, Middle, Last)  JAMIE MARTIN OSBURN, JR			eath Day Year 26, 2006	3. Time of Death 1431 hrs	
		Facility Name (if not institution, give street and number)     Southern Maryland Hospital	4b. City, Town, or L Waldorf	ocation of Death	4c. County of Death Prince George's		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs las		If Under 24Hrs. 8. Date of E	Birth (MM/DD/YYYY) 9. Birt		
" Director		216-75-6874 1X M 2 F	Yrs. Months Days	Hours Min	1,2006 MARYLAND		
any			own or Location			10d Inside City Limits	
nyland 8a-f show 11 once,	ector	MARYLAND CHARLES WA  10e. Street and Number	LDORF		10g Citizen of What Cour	1 Yes 2 XNo	
the Ma a or 28	Dire	2640SCHULT PLACE	206	0.1		,.	
n with ms 23 be no	eral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hisp	anic Origin? (Specify Yes or N		can Indian, Black,	
fter death l", or ite	y Funer	1 XNever Married 2 Married Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No	Mexican, Puerto Rican, etc.)  specify:	White, etc.	TE	
iours a	ed by	15. Decedent's Education (Specify only highest grade completed)	6a. Decedent's Usual Occupation during most of working life.		16b Kind of Business/li		
Baltimore, MD 21215-0036  permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time X7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ompleted	College (1-4 or 5+)	INFANT	50 NOT use retired)	N/A		
215-( be filed v mal Hygi rked oth	e C	17. Father's Name (First, Middle, Last)  JAMIE M. OSBURN, SR.	18	3.Mother's Name (First, Middle LYDIA JEAN			
212 212 201d be Menta mark ic even	ТоВ	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Address (Street			Zip Code)	
MD nd 2 sho alth and m 27 is aumati		JAMIE M. OSBURN, SRFATHE	R 2640 SCHU	LT PLACE, WAI	LDORF, MARYI	LAND 20601	
ore, of Hea If iter			ace of Disposition (Name of ceme ematory or other place)	etery, Date	20c. Location - City or	Town, State	
Baltimore, permit Pages I ar Department of Hee Important: If ite	Ц	4 Donation 5 Other Specify WAS	HINGTON NATI	ONAL CEM 11-	-\$-06 SUITI	JAND, MD	
Bal permi Depar Impo		21. Signature of Funeral Service Licensee M004	2. Name and Address of RAYMOND	of Facility FUNERAL SERV	VICE, P.A.		
Physician		23a Part I. Enter the disease, or complication with caused the death. D failure. List only one cause on each line	nte in m e	Cch MARYHAND ry 2	or heart	Approximate Interval	
/Medical Examiner	4	Immediate Cause (Final disease a. Sudden unexplained	l death in infancy			Between Onset and Death	
		or condition resulting in death)  Due to (or as a consequence of):					
	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   Due to (or as a consequence of):					
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be exe	dical	X unpended $X$ amended $1,23a,27$ ,	.28a-f, perME, g862	2. 12/21/06 TT			
6876( certificate rding physicate because the b	ın/Me	IF FEMALE. 23b. Was decedent pregnant in the 23c. If yes, outcome of pregna		Ectopic pregnancy	23d. Date of delivery Month D	ay Year	
Box 68760, re death certificate be executed the attending physician and ed for use as the burial - transit	sicia	past 12 months?  1 Yes 2 No 9 Unknown 0 Unknown 1	2	coopid pregnancy	Month D	ay Year	
the death of the atter	Phys	Part II. Other significant conditions contributing to death but not rest	ulting in the underlying source of	ton in Bort I 220 Did	tobacco use contribute to t		
P.O es that t gned by	þ	Contributing to death but not resi	aning in the underlying cause giv		es 2 No 3 Prob		
n of Vital Records, P.O. ing Physician: The law requires that th After this certificate has been signed by tuneral director, page 2 should be detach	eted		-	24a. Was		opsy findings available	
eco he law ite has	omplet				ormed? death?	ompletion of cause of	
al R an: T ertifica	O C	25. Was case referred to medical		of Death (Check only one)	2 No 1 Yes	s 2 No	
of Vital Records, ng Physician: The law requir Net this certificate has been s moral director, page 2 should	To B	I W 163 Z NO	R/Outpatient 3 DOA	ther Nursing Home 5	Residence 6 Other:	Scene	
n of V ding Phy h After the		27. Manner of Death  1 Natural 5 Pending 28a. Date of Injury (Month, Day,Year)	8b Time of Injury 28c. Injury	at Work? 28d. Describe	how injury occurred		
Division tal or Attendir rs after death al Director: A	ertification	2 Accident Investigation and 10/26/2006	Fnd 2:00 pm ne, farm, street, factory, office bu	UIIKIIOWII	l (Street and Number or Run	al Poute Number City	
Divis	ertif	Suicide A Could not be	n residence	or Town,	State) 2640 Schul	t Place	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	O	29a Certifier 1 Certifying Physician: To the best of my knowledge	, death occurred at the time, date	e and place, and due to the cau	use(s) and manner as starte		
To the Hos within 24 h	Medical	one) 2 Medical Examiner: On the basis of examination and and manner stated.					
	Σ	29b Signature and title of certifier	29c License		29d Date signed (Mon		
		30. Name and address of person who completed cause of death (Item 2:	O.C.M	.C.	October 27, 2006		
		Carol Allan, MD Assistant Medical Examiner 1		re. MD 21201			

State Registrar

31. Date filed (Month) Pay/Year) 3 2006

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [ 35841 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death October 22, 2006 Year **Physician** Donald W. Patterson 3:00A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12807 Prestwick Drive Ft. Washington Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 8/5/1935 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 149-28-0695 Director New Jersey Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural; or Items 23s or 28e-1 show any injury or other traumatic event, the Mastical Examinar more page. 10c. City, Town or Location 10b County 10a State 10d. Inside City Limits Prince George Ft. Washington Maryland 1 ☐ Yes 2 📉 No Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20744 12807 Prestwick Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 🎇 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 XNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Limousine Service Driver 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louise Miller Miller Patterson William 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12807 Prestwick Dr. Ft. washington, Md. 20744 Geraldine Patterson/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial ∠ XCremation 3 □Removal from State 10/25/2006 Kalas Crematory 4 Donagon 5 Other (Specify) Edgewater, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland alke Int1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dilated Candio Physician disease or condition resulting in death) /Medical Examiner Samential list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ettending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 □Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Hunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy performed 2 No 1 Yes 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 27 Manner of Death 28c, injury at Work? 28b. Time of 28d. Describe how injury occurred After 1. Natural 2 Accident 5 Pending investigation 1 Tes 2 No Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 06 MD 8172 Janac C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 1328 Southern Ave, S.E. Washington, DC 20032

DHMH 17 Rev 1/2001

State

Registrar

Khosrow Davachi

OCT 26 2006

31. Date filed (Month, Day, Year)

32. Registrar's Signature

06-08359

Please Type or Print in Black Indelible Ink Jeffrey Prince State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day November 4, 2006 0434 hrs Medical Examiner Jeffrey Faulk Prince c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Fikton Cecil 108 Liberty Lane If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** oreign Months Days Hours Min Director CountrySouth 1X M 2 F 42 01/04/1964 221-56-2147 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Ę 10a State Yes 2X No Newark 28a-f show DE New Castle with the Maryland Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 23a or 259 South Thistle Way 19702 USA Funeral 12. Was Decedent Ever in U.S 13 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, 8lack death v Armed Forces White etc. 1 Never Married 2 X Married 2 X No Yes If Yes, Give Year after 1 Yes 2 X No specify. Specify: White Widowed Divorced "natural" ð 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of 8usiness/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Flementary/Secondary (0-12) 72 h is marked other than atic event, the Medical Baltimore, MD 21215-0036 Housekeeper Medical ges I and 2 should be filed within of Health and Mental Hygiene
If item 27 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ralph Price, Sr. Mary Faulk 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) South Thistle Way, Newark, DE 19702 <u> Lisa Prince - Wife</u> 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a Method of Disposition crematory or other place) 2 Cremation 3 Removal from State Department of Anatomy Gifts 11/6/06 Hanover, ation 5 Other Spec 22. Name and Address of Facility CC0442 Beeson Funeral Ho 2053 Pulaski Hwy, Home of Vy, Newar 09 6 Newark k, DE Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician failure. List only one cause on each line **8etween Onset and** /Medical Death Hypertensive cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and rsician/Medical **Y** UNPENDED AMENDED #23a,PII,27,perME,g861,11/21/06 TT Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 V Unknown Cirrhosis Completed 24a Was ar 24b Were autopsy findings available autopsy prior to completion of cause of this certificate has death? performed? ✓ Yes 2 No 1 🗸 Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26 Place of Death (Check only one) Be Other<sub>4</sub> examiner? ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✓ Other: Scene Inpatient 2 1 V Yes 28a. Date of Injury (Month, Day, Year 28b. Time of Injury After 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 1 Yes 2 No 5 Pending 24 hours after death. Funeral Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 1 within 2 29b Signature and title of certifier 29c. License number 29d. Date signed (Month. Day Year) O.C.M.E. November 4, 2006 person who completed cause of death (Item 23a)

State Registra

DHMH 17 Rev 1/2001

OCME 2006

Jack Titus MD.

31. Date filed (Month, Day, Year)

**ORIGINAL** 

111 Penn Street, Baltimore, MD 21201

Deputy Chief Medical Examiner

Division of Vital Records, P.O. Box 68760 the Hospitei or Attending Physician: To the Function after death.
To the Funerel Director: Aft

28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide t Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 10 D0021031 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20604 MICHAEL A. LEATHERWOOD, MD 12070 OLD LINE CENTER, STE. 302, WALDORF, MARYLAND

State Registrar

DHMH 17 Rev 1/2001

31. Date liled (Month, Day, Year)

32. Refistrar's Signature Ween & Spark 7. Age (In yrs. last birthday)

10c. City, Town or Location

Hyattsville

69

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Oates:

College (1-4or 5+) 5+

Certificate of Death

Hyattsville

10f. Zip Code

20782

1 ☐ Yes 2 No

Attorney at Law

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

Hours

Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Alice Alsop

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2. Date of Death

8. Date of Birth (Month, Day, Year)

9,

October 16, 2006

1936

U.S.A.

4c. County of Death

10g. Citizen of What Country?

Specify:

16b. Kind of Business/Industry

Prince George's

14. Race - American Indian, Black, White, etc.

Estate and Probate Law

White

Month

18. Mother's Name (First, Middle, Maiden Surname)

35844

9:50 p M

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 X No

Washington,

10a. State

213-40-6525

10e. Street and Number

Usual Residence of Decedent

10b. County

Maryland Prince George's

15. Decedent's Education (Specify only highest grade completed)

3919 Commander Drive

1 Never Married 2 Married

3 

Widowed 4 □ Divorced

Elementary/Secondary (0-12)

Basil Pickett

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type, Print)

Sinclair Pickett

1**⊠**M 2□F

**Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

Be

**Funeral** 

Director

filed within 72 hours after death with the Maryland ir then "natural, or iteme 23a or 28a-f ehovite Medical Examiner must be notified at

Baltimore, Maryland 21215-0036 Stacy Pickett Trimble - Daughter 45 Aspen Woods Drive, Sunderland, Maryland 20689 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State permit. Pege Depertment of Important: If eny Injury or SDCS. 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 10/20/2006 Silver Spring, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 +: tonslance 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac Arrythmia /Medical Due to (or as a consequence of) Examiner Cardiomyopathy Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-transit Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 □ Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed d be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should b 1 ☐ Yes 2 ☐ No 3X Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 2 No 2 🗆 No 1 Yes 1 Yes After this certific funeral director. Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🕅 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred t Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident rector: by the 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) tilled in by 4 Homicide គ within 24 hours a To the Funeral ( 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Keek D0009357 October 19, 2006 hell 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5804 Baltimore Avenue, Hyattsville, Maryland 20781-1623 J. Richard Lilly, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 23 2006 Registrar DHMH 17 Rev 1/2001

		1 - For State Registrar	State of Ma		d / Depa		of H	lealth a				200	6	35	845
		1. Decedent's Name (First, Middle, Las	t)	-						2. Date of De		. ,	/	3. Time	of Death
Physicia /Medic		Edward Penansky								Month 10/19	Day 200		rear	9:00	Р
Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, 7	Town, or	Location of	of Death			County of	Death		
		8100 Connecticut A	Avenue, Apt	t. #8	322	Chevy		ise				ontgo	mery	7	
Funeral		5. Social Security Number 6. Se	7. Age	(In yrs. I	ast birthday)	If Under Months	1 Year Days	If Under:	24 Hrs. Min.	8. Date of Bin (Month, Da	h y, Year)		9. Birthpl Count	ace (State	or Foreign
Director		015-16-60/8	FIM SOL	86	S Yrs.					12/18/	1919			n, M	
and war		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation							10	d Inside (	City Limits
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h the Marylan or 28a-f ehow	rec	MD Montgomen  10e. Street and Number	У	Che	vy Cha	se 10f. Zip	Code				10g. Citi	zen of Wh	at Count	nv?	
3a or	₽	8100 Connecticut A	venue. Ant	- #5	322	208					U.S			.,.	
deeth w	Funeral Director	11. Marital Status	12. Was Decedent Ev					ispanic Orig	gin? (Spe	cify Yes or No Rican, etc.)		14. Race	- America	n Indian,	
after or Ite	Ē	1 ☐ Never Married 2 🛣 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	0					, Puerto	Rican, etc.)			White, e	itc.	
rel',	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:								Specify:	Whi	te			
72 h	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)		(Give	dent's Usua kind of won	k done a	during most	t of workii	ng	16b. Ki	nd of Bus	iness/Ind	ustry	
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iled v dygie ther t	ပိ	12 17. Father's Name (First, Middle, Last)			Owne	r & Ma	anag		do Nomo	(First, Middle,		ies'		rel	
ntal he dolor	Be	Harry Penansky							Mar		Malden	Sumame,	,		
2 should be filed within 72 hours after deeth with the Maryland and Manial Hygiene. Is marked other then "neturel", or Items 23a or 28a-f show eumatic event, the Mad cal Experiment must be coulding a	ဍ	19a. Informant's Name/Relationship (T	Voe Print)		10h Mailir	a Address	(Street a			l Route Numbe	ar City o	r Tour C	tata Zin	Codol	
end 2 s ealth ar n 27 le		Steven Penansky -			7806					Betheso				C000)	
Hear tem other		20a. Method of Disposition		20b. Pl	ace of Dispo	sition (Nam	e of			ate		cation - C		vn, State	
Pages nent of ant: If It any or o		1 XBurial 2 ☐ Cremation 3X☐ 4 ☐ Donation 5 ☐ Other (Specify			emetery, crer con Me				0/22	/2006	Char	ron,	M/ A		
1 글 논란을 .		21. Signature of Funeral Service Licens		Dilai		. Name and				72000	Silai	LUII	FIA		
Per Per Per Per Per Per Per Per Per Per		(a) (a)			E	dward	Sag	el Fu	nera	1 Direc	ction				
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	plications that caused to	he death	. Do not ent	er the mode	of dying	g, such as	cardiac o	r respiratory a	rest,	lle,		0852 Approxima Interval Be	ite stween
Physician		Immediate Cause (Final disease or condition	Respirat		Failu	re								Onset and	Death
/Medical		resulting in death)	a. Due to (or as a											T WE	- A
Examiner		Sequentially list conditions	. Restrict	ive	Lung 1	Diseas	se							3 yea	ars
p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a		,										
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0 % 0	dical													irs	
sath certifica ettending ph for use as th	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o	f pregnai	nev						Ţ,	22d Data	of dollars		
etter for c	clar	in the past 12 months?	1 □ Live birth 2 4 □ Pregnant at ti			Ectopic pre					•	23d. Date Monti		y Day	Year
by the destached	hys	9 Unknown	9□ Unknown												
or Attending Physician: The law requires that the death certifical ifler deeth. Director; Atler this certificele has been signed by the ettending phin by the funeral director, page 2 should be detached for use as the	by Physician/Med	Part II. Other significant conditions co	entributing to death but	not resu	Ilting in the u	nderlying ca	use give	en in Part I.		23e. Did t	obacco u	se contrib	ute to the	e cause of	death?
w requires t been signe should be										10	fes 2[	□No 3	Proba	bly 4 🗘	[Unknown
e law re has be	plet									24a. Was		24b. We	ere autop	sy findings	s available
The I	Completed										rmed? 2 🔯 No	de	ath?	piletion of No	cause or
certificete	Be (	25. Was case referred to medical examiner?							of Death	(Check only o				21	
Physic this o	ဥ	1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inpatien		ER/Outpatier			4 🗀 1401	rsing Hor	ne 5ሺ Resid	dence (	5 □Other	(Specify)	)	
After Uner	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury		Sc. Injury Work		1	28d. Describe I	now injur	y occurred	t		
deeth deeth stor; the t	cat	2 Accident investigation 3 Suicide 6 Could not be	200 Place of Injur	A . A . b . a	m o form -t-	M		Yes 2 □ i		206 1	24				
or A effer Direction by	Certification:	4 ☐ Homicide determined	28e. Place of Injur building, etc.	(Specify	me, iarm, str	eet, tactory,	опісе		4	28f. Location (3 City or Tov			or Hurai	Houle Nul	n <i>ber</i> ,
spital ours nerel filled	S I	29a. Certifier 1 X Certifying Phy	ysician: To the best of	my know	wledge, death	occurred a	it the tim	e date an	d place, a	and due to the	rause(s)	and many	ner as eta	ited	
To the Hospital or Attending Ph within 24 hours effer deeth. To the Funeral Director; Atter th completely filled in by the funeral	edical	(Check only 2 Medical Exam one)	iner: On the basis of and manner state	examinat	ion and/or in	estigation,	in my op	pinion, deat	th occurre	ed at the time,	date and	place, an	d due to	the cause	s)
To th Within To th	Me	29b. Signature and title of certifier		1	,	29c.	License	number			29d. Dat	e signed (	Month, D	ay, Year)	
(0		XI Cons	26/2	cel	9	DO	056	065			10/2	20/20	06		
Ψ		30. Name and address of person who d	completed cause of dea	ath (Item	23a) (Type,	Print)					•				
		Carlos E. Picone,			scons	in Ave	. S	uite	930	Chev	y Ch	ase,	MD	20815	<u>;                                    </u>
Sta		31. Date filed (Month, Day, Year)	32. Asgistrar	's Signat	The La	Seres!									7,
Registr	ar	OCT 2 3	-UUU MELA		- 57										

			For State Registrar	State of M	aryland /		artment rtificate					iene	006	35	846	
	División.		1. Decedent's Name (First, Middle, La	st)			2. Date of Dea Month					h Day	Year	3. Time o	f Death	
	Physici /Medic		Margaret Alic	e Pow	ers						October			2:30	a M	
	Examin	er	4a. Fecility Name (If not institution, giv				4b. City, Town, or Location of Death Adelphi					4c. County of Death				
			Hillhaven Nursin  5. Social Security Number 6. S		Inc.	intholous	If Under		If Under	24 Hrs c	3. Date of Birth		Prince Geor			
,	Funeral Director			☐ M 203F	Yrs.	Months	Days	Hours	Min.	(Month, Day, pril 10	Year)	918	thplace (State ountry) New Yo	-		
			Usuel Residence of Decedent				•									
	ehow	F	10a. State 10b. County		10c. City, To									10d. Inside C		
	Me W.	Director	Maryland Prince G	eorge's	Ad	elph	_								2 🗗 No	
	with t		3210 Powder Mil	1 Road			10f. Zip		0783		1	0g. Citize	en of What Co USA	ountry?		
	me 23	Funeral	11. Marital Status	12. Was Decedent		13.1	Was Deced			igin? (Speci	ify Yes or No-	14	1. Race - Ame	rican Indian,		
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "neturel", or Itams 23e or 28e-f ehow event, the Medical Excriber mast be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2  Armed Forces?  If Yes, Give Year or Dates:			fYes, spec 1☐Yes 2				ify Yes or No- ican, etc.)	s	Black, White, etc.  Specify: White			
5-0	72 hc	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working									16b. Kind	6b. Kind of Business/Industry			
121	within ene. then "	ďμ	Elementary/Secondary (0-12)	College (1-4or	5+)	life. I	DO NOT us	e retired)				_				
2	Hygie ther t nt, in		17. Father's Name (First, Middle, Last,				Offic	е ма			First, Middle, A			Gover	nment	
ano	2 should be filed v and Mental Hygie !e marked other t raumatic event, III	To Be	John C. Powers						TO. MIORITE		se J. V		umame			
ary	shoul nd Ma mari	Ĕ	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural									City or	Town, State, 2	Zip Code)		
Ž	s 1 and 2 should if Health and Men Item 27 is marks other traumatic		Francis E. Power	harlest	on,	SC 294	12									
atimore,	permit. Pages 1 and 2 a Department of Health ar Importent: If Item 27 ie any Injury or other trau once.		20a. Method of Disposition 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Topople (Specify)									Oc. Location - City or Town, State				
<del>=</del>	partmit.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Fu										ria, Ne	w York		
4	183558		James 5 boly 500 University Blvd, W, Silver Spring, MD 209													
			shock, of heart failure. List only one cause on each line.												tween	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)											Onset and 3 Days		
	Examiner			Due to (or as	a consequence	9 of):										
		ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence	e of):										
	cate be executed physicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events	c												
0	e exe		resulting in death) Last		a consequence	e of):									-	
68760,	ate b hysic the bi	dicai	•	d												
	entific ding p	/Mec	IF FEMALE:	23c. If yes, outcome	of acadanasas											
D. Box	The law requires that the death certificate be executed site hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐Live birth 4 ☐ Pregnant a	2 Fetal deal		Ectopic pre Other (spe		-			23	ld. Date of del Month		Year	
P.0	thet the de led by the a		Part II. Other significant conditions of	ontributing to death h	ut not resulting	in the u	nderhing ca	NIEG GRIG	n in Part I		23e Did tob	2000 1164	a contribute to	the cause of	doath?	
ds,	uires the signed id be de	d by	Dementia, Chroni					-		•	1 □ Ye			robably 4		
20	w requir been si should	lete	Peripheral Vascu								24a. Was ar	, ,	24h Ware a	utopsy findings	avadable	
of Vital Records,	he lav	Completed by	relipheral vascu	rar biseas	,e						autops	y ned?	prior to death?	completion of	cause of	
tal		0	25. Was case referred to medical						26 Place	of Death /	1 ☐ Yes 2 Check only one	No No	1 🗆 Yes	2□ No		
<b>†</b>	Physician: this certific ral director,	To B	examiner? 1 🗌 Yes - 2 No	Hospital: 1 ☐ Inpatio	ent 2 ER/C	outpatien	t 3 DO	A Othe			e 5 ☐ Reside		☐Other (Spe	cify)		
	ding Pt J. After th funeral		27. Manner of Death  1 SNatural 5 Pending	28a. Date of Inju (Month, Da	y Year) 28b.	Time of	28	Bc. Injury Work			d. Describe ho					
sio	tendl leath. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not b				М		'es 2 □							
Division	tal or Attendl is efter death. al Director: A ed in by the fu	Certification:	289. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  287. Location (Street and Number or Rural Route Number or Bural Route Number or Rural Ro											nber,		
	To the Hospital or Attending Ph within 24 hours effer death.  To the Funeral Director: Affer th completely filled in by the funeral	edical	29a. Certifier (Check only one)  1 X Certifying Ph 2 Medical Example 1 Medical Example 2 Medical Example 1 Medical Examp	nysician: To the best niner: On the basis o and manner st	f examination a	ge, death and/or in	occurred a vestigation,	at the tim in my op	e, date an inion, dea	nd place, an oth occurred	d due to the ca	ause(s) a ate and p	nd manner as lace, and due	s stated. to the cause(	s)	
	Withi Som	W	29b. Signature and title of certifier	12001			290.	License	number	3-1			signed (Mont			
			30. Name and address of person who	completed cause of	leath (Item 23a	) (Type,	Print)								200	
	منسين		HOBYN P. MO	DC1250	U 10801	w	KWa	1 ac	RIVE	5 Su	10th 300	5 5	LLVER	SPRINC	3 MD	
	Sta Registr		31. Date filed (Month, Day, Year)  OCT 2 3 2	32. Registi	ar's Signature	1	sele									
DH	MH 17 Rev 1/2		00120	J. Marie	25	STA										

,	ł		1 - For State of Maryland		artment o			nd M		giene Reg. No.		35	847
	Physici	Total Control	1. Decedent's Name (First, Middle, Last)  Carolyn Elizabeth Perrick						2. Date of Dea Month Novemb	er 5	, 200e	3. Tim	e of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, To	wn, or	Location of	Death			County of D	eath	
			Anne Arundel Medical Center		1	_	olis				Anne	Arunde	21
2 12	Funeral Director		5. Social Security Number 6. Sex 1 M 2 1 F 62 62 6. Sex 6	birthday) Yrs.	Months [	Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day 10/7/1	h y, Year) 944		Birthplace (Sta Country) ashing t	
	and W		Usual Residence of Decedent           10a. State         10b. County         10c. City, To.	own or Lo	cation							10d. Insid	le City Limits
	Maryli f eho	ò	Maryland Anne Arundel	Da	vidson	7 ÷ 1 -	ما					1 🗆	Yes 2∭XNo
	r 28a	rec	10e. Street and Number	Da	10f. Zip C		LC			10g. Citi	zen of What	Country?	
	th with	a D	319 Dodon Road		1	035					JSA		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants if Item 27 is marked other than "natural", or Items 23a or 28a-f show importants if Item 27 is marked other than "natural", or Items 23a or 28a-f show stry injury or other treumatic event, Ira Medical Exaction of Irania ke Incitities at ance.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Give 1 Yes, Give 1 Year or Dates:		Was Deceder If Yes, specify 1 ☐ Yes 2 🕽			jin? (Spe Puerto	ecify Yes or No- Rican, etc.)		14. Race - A Black, W Specify:	merican India hite, etc. White	n,
Maryland 21215-0036	nin 72 hou In "natura Medical E	Completed	**	6a. Dece (Give life.	dent's Usual ( kind of work DO NOT use	Occupa done d retired,	tion uring most	of works	ng	16b. Ki	nd of Busine	ss/Industry	
21	giene giene er the	Com	4 years	Sy	stems A	Ana.						s Admir	nistrat
land	12 should be filed within h and Mental Hygiene. 7 is marked other than "Ireumatic event, the Mec	To Be (	17. Father's Name (First, Middle, Last)  Jack Baker				18. Mother		elen La				
ary	shou ind M inmar umat	-	19a. Informant's Name/Relationship (Type, Print)	9b. Maili	ng Address (S	Street a	nd Numbe	r or Rura	ıl Route Numbe	er, City o	r Town, State	e, Zip Code)	
	and 2 laith s alth s r 27 is		Jason C. Perrick/ Son						sonvill				
Jore	ages 1 and of He		I M Buriai 2   Cremation 3   Hemovarirom State		osition (Name matory or other Cemete		1		-06			or Town, Stateville,	
Baltimore,	permit. Pa Departme Important eny injury		4 Donation 5 Other (Specify) Lake:  21. Signate Service Licensee	22	2. Name and	Addres	s of Facility	Ge	orge P.	Ka1	as Fu	neral H	Iome
<u> </u>	#9 # # 9	Ш	100000								dgewater, MD 21037		
Ì	Physician		23a. Part1. Enter the disease, or complications that caused the death. If shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition as a. PAN CREATERS IN CAREAGE OF CAUSE OF							rrest,		Onset	Imate I Between and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequen	ce of):									
3	P #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	ce of):									
· .	ate be executed thysicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C	ce of):									
68760,	cate be physicle the bur	cal	d										
P.O. Box 6	ath certif ttending or use as	Physiclan/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ √√₀  9 □ Unknown  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal de  4 □ Pregnant at time of death					23d. Date of Month	delivery Day	Year			
rds, P.	quires that the dein signed by the a	d by Ph	Part II. Other significant conditions contributing to death but not resulting HEPATICENCEPHAL			ise give	en in Part I.			obacco u Yes 2		e to the cause	of death?
Records,	ding Physician: The law requir h. After this certificate has been si funeral director, page 2 should I	Completed by							24a. Was autor perfo		prior death		of cause of
Vital	ian: artifica ctor, p	BeC	25. Was case referred to medical examiner?				26. Place	of Deat	(Check only o		<u> </u>		
of <	hysic his ce	P	1 Yes 2 00 Hospital: 1 npatient 2 ER	/Outpatie			4 🗆 Nu		me 5 Resi			Specify)	
n o	On 00 00	ino ::	1 Pending (Month, Day Year)	lb. Time o Injury		Work	rat ∢? Yes 2 □ I		28d. Describe l	how injui	ry occurred		
Division	Attending or death. ector: After by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury. At home	, farm, st	reet, factory,		105 2 1		28f. Location (	Street an	nd Number o	r Rural Route	Number,
οįς	after after Dire	erti	4 Homicide determined building, etc. (Specify)	, . ,	, ,				City or Tox	wn, State	<del>)</del> )		
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Att completely filled in by the fun	Medical C	29a. Certifier (Check only one)  1										use(s)
	To the within To the comple	Me	29h. Signature and title of certifie	ا دی	29c.	License	number			29d. Da	te signed (M	onth, Day, Ye	ar)
	. >- 0		· malle mom	F-1	- 0	3	837	18	U		_	200	
	25		30. Name and address of person who completed cause of death (Item 23	ia) (Type	Print)	vΑ	POL	15	MD	M	Any	RIC	MD
-		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature		A . W .				2140	ĺ			
	Regist	rar	NGV 1 3 2006	K de	DOME!								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Gene Harland Perry October 27, 2006 6:30 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Charlotte Hall Veterans Home Saint Mary's Charlotte Hall If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 15kM 2□ F 89 Director 486-09-2636 09/20/1917 Nebraska Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinat must be notified at 1 ☐ Yes 2 X No Director Virginia Fairfax McLean 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? P.O. Box 419 22101 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Ill important: If item 27 is marked other than "natural", or Item any injury or other traumatic event. The Wedley Promessing. 1 2 Yes 2 No 1/4/45. If Yes, Give 1/4/45. Year or Dates: 8/22/46 1 Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry United States Elementary/Secondary (0-12) College (1-4or 5+) Postal Service Postal Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George H. Perry Monta Passel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrea J. Sloan/Guardian P.O. Box 419, McLean, Virginia 22101-0419 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Funeral Choices of or other place 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State November 1, Chantilly, Virginia 4 □ Donation 5 □ Other (Specify) Chantilly 21. Signature of Funeral Service Licensee Name and Address of Facility Funeral Choices of Chantilly 14522L Lee Road, Chantilly, Virginia 20151 the 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-transit Atria and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician Physician/Medlcal IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Yes 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? I ☐ Yes 2 ☐ No 1 ☐ Yes 2010 I or Attending Physicien: after death. Director; After this certifice 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Thursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ HO 1 Inpatient 3 DOA 2 ER/Outpatient Certification: 28d. Describe how injury occurred injury at Work? 1 Natural 5 Pending investigation 1 🗌 Yes 2 No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D To the Hospital The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who o imple ed cause of death (Item 23a) (Type, Print) rince Fredrick MD 20678 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 3 2006 Registrar

06-07903 Janet Reid

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea. No Registrar 2 Date of Death Decedent's Name (First, Middle,Last) Phisician Month Day October 21, 2006 1135 hrs **Medical Examiner** Reid Janet 4c. County of Death 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore** University Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs 5. Social Security Number . Age (In yrs. last birthday) **Funeral** Director M 2 Yrs 09/14/1955 Virginia 30-88-1935 Usual Residence of Decedent 10d Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 X Yes 2 No 28a-f show 23a or 28a-f sho notified at once. Prince George's Brandywine Maryland| Director 10f. Zip Code 10g Citizen of What Country 10e Street and Number 20613 7810 Lusbys Turn United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, 8lack 12. Was Decedent Ever in U.S. Funeral 11 Marital Status or items must be 2 X Married Armed Forces? 1 Never Married Yes 2 X No Specify Divorced Give Year Yes 2 X No specify: Black 3 Widowed "natural", <u></u> 16a, Decedent's Usual Occupation (Give kind of work done 6b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages I and 2 should be filed within 72 hours yen of Health and Mental Hygiene ant: If item 27 is marked other than "natur: yr other transmatic event, the Medical Exami during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) FBI-Government Para-Legal 18. Mother's Name (First, Middle, Maiden Surname 17 Father's Name (First, Middle, Last) Be Katie Mason Ernest Mears 19a Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Craig Reid/Husband 7810 Lusbys Turn, Brandywine, MD 20613 Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a Method of Disposition crematory or other place) X<sub>8urial 2</sub> Cremation 3 Removal from State Important: In injury or 10/28/2006 Clinton, MD Resurrection Cemetery Other Specify. Donation 5 22. Name and Address of Facility 21 Signature of Funeral Service Licenses Stewart Funeral Home 4001 Benning Rd., NE Wash., DC 20019 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and List only one cause on each line /Medical Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause. Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last certificate be executed and Physician/Medical UNPENDED AMENDED 23d Date of delivery IF FEMALE 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o. ð Yes 2 V No 3 Probably 4 Unknown ۵. Completed Records, 24b Were autopsy findings available 24a Was an autopsy prior to completion of cause of performed? death? ✔ Yes 2 ✓ Yes 26 Place of Death (Check only one) 25 Was case referred to medical of Vital Be Other<sub>4</sub> Hospital: 1 Nursing Home 5 Inpatient 2 V ER/Outpatient 3 DOA Residence 6 this 1 🗸 Yes 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d, Describe how injury occurred After 27 Manner of Death the Hospital or Attending Certification: Passenger auto auto collision Oct 21, 2006 1008 hrs Yes 2 V No Natural Division Pending the 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town State determined Crain Highway & Croom Road, Marlboro, MD (Specify) Major Road / Highway 24 hours a Funeral 1 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d Date signed (Month, Day, Year) 29b. Signature and title of cert 29c. License number October 22, 2006 O.C.M.E. 30. Name and completed cause of death (Item 23a) Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar

**ORIGINAL** 

Mary & Ripple MD.

State of Maryland / Department of Health and Mental Hygien® 0.0 C

			Certificate of Death		eg. No.	33030								
	Physici /Medic	al	1. Decedent's Name (First, Middle, Last)  ROXANNA PARKER ROUPAS  4a. Facility Name (If not institution, give street end number)  4b. City, Town, or Lot	2. Date of Dea Month		och 5 Am								
	Funeral Director		Villa Rosa Nursing Home  Mitchell  5. Social Security Number  6. Sex  1 M 2 F 97  Yrs.  Months Days Hours Min.	ville  8. Date of Birth (Month, Day 10/28/1		George's  Birthplace (State or Foreign Country)  orth Carolina								
	D .	tor	Usual Residence of Decedent  10a. State  10b. County  Maryland Prince George's Mitchellville	20/20/1		10d. Inside City Limits t Yes 2 □ No								
15	3e or 28a t be notif	Funeral Director	10e. Street and Number 3800 Lottsford Vista Road 20716	1	0g. Citizen of What USA	Country?								
flaryland 21215-UUZU 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is merked other than "neturel", or iteme 23e or 28e-f show surmatic event, the Medical Examiner must be notified at		11. Marital Status  12. Was Decedent Ever in U,S. Armed Forces?  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U,S. Armed Forces?  1 □ Yes 2 ☒ No Specify:  1 □ Yes 2 ☒ No Specify:	pecify Yes or No- o Rican, etc.) 14. Race Black Specify:		- American Indian, , White, etc. White									
	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  1 1  16a. Decedent's Usual Occupation (Give kind of work done during most of working) (iffe. DO NOT use retired)  Waitress	ng	16b. Kind of Busine Restaura										
Maryland	uld be filed w flental Hygier rked other th tic event, the	To Be Co	17. Father's Name (First, Middle, Lest)  William Parker  Ada Nic		Maiden Sumame)									
Mar	id 2 sho Ith and 17 is ma traum		Phyllis F. Leps - Daughter 8119 Orville St., Alex	nd Number or Rural Route Number, City or Town, State, Zip Code) St., Alexandria, VA 22309										
e C	permit. Pages 1 ar Department of Heal Important: If Item 2 eny Injury or other once.		Church Cemetery	Date 20c. Location - City or Town, State  10/24/06 Brevard, NC										
g	Depar Depar Impor eny ir		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Gasch's Funeral Home, P.A.  4739 Baltimore Ave., Hyattsville, MD 20781											
	Physician /Medical Examiner		23a Part1. Enter the disease, or committations that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence ol):	Prespiratory arr	est,	Approximate Interval Between Onset and Death								
0X 6876U,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be deteched for use es the buriel-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	<b>~</b> 1		414								
P.O. Box	es that the death cel igned by the attendir be deteched for use	Physicia	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			oute to the cause of desth?  Probably 4 Unknown								
Vital Records,	w requires the been signer should be d	Completed by		24a. Was a		4b. Were autopsy findings available prior to completion of cause of death?								
tal He	on: The lar	Be Comp	25. Was case referred to medical 26. Place of Death	1 UY		1 ☐ Yes 2 ☐ No								
o	ysicie is cer direct	To B	examiner?		ence 6 Other (5	Specify)								
DIVISION O	To the Hospital or Attending Physicien: The law within 24 Hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	1 Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No	28f. Location (S	ow injury occurred	r Rural Route Number,								
5	tal or Ars after safter el Directed in by	n, State)												
	To the Hospital within 24 hours a To the Funerel I completely filled	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, each one one of the companies of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the c ad at the time, d	ause(s) and manne late and place, and	r as stated. due to the cause(s)								
	Vithiu To th	M	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, i											
- (	50		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Clary Colons Polynomy An 9500 ANAPOLY	_bnha	an	2.706								
Ì	Sta Registr		31. Date filed (Month, Day, Year)  OCT 2 3 2006  32. Registrar's Signature											

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene 11 15

25051

		-	For State Registrar	State of Mai		artment of Hear			eg. No.	33031				
			Decedent's Name (First, Middle, Last)	)				2. Date of Deat Month	h Day Year	3. Time of Death				
	Physicia /Medic		Helen G. Raf	fal- Clark				October		10:21a M				
rio	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or Lo			4c. County of Dea					
			4818 Wheeler Road		<del> </del>	Oxon Hil	.1 Under 24 Hrs.		Prince Georges					
	Funeral Director		300 32 3223	M 2 F	(In yrs. last birthday		Hours Min.	8. Date of Birth (Month, Day, Oct. 13,		thplace (State or Foreign ountry) Les, Ca.				
	aryland show		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L		10d. Inside City Limits 1y Yes 2 □ No							
	Bea-f	Director	Maryland Prince (	Georges	Oxon H				0g. Citizen of What C					
	with t	급	10e. Street and Number			10f. Zip Code 20745		'	United St					
	eath	erai	4818 Wheeler Road	12. Was Decedent Ex	ver in U.S. 13.	Was Decedent of Hispa II Yes, specify Cuban, I		ecify Yes or No-	14. Race - Am	erican Indian,				
Maryland 21215-0036	s i end 2 should be filed within 72 hours after death with the Maryland if Heelth and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be motified at	by Funerai	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			Mexican, Puerto Specify:	Rican, etc.)	Black, Whi					
2-0	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. Dec	edent's Usual Occupation be kind of work done during DO NOT use retired)	n ing most of worki	ng	16b. Kind of Business	/Industry				
21		mpie	Elementary/Secondary (0-12)	College (1-4or 5+	) life.	DO NOT use retired) ninistrativ	e Assist	ant	Governme	ent				
2	iled w tygier her th		12 17. Father's Name (First, Middle, Last)		Au				Maiden Sumame)					
anc	ntal h	Be	Andreas Rafal				Sarah (		,					
2	should ad Me mark matic	ဥ	19a. Informant's Name/Relationship (7)	; City or Town, State,	Zip Code)									
	nd 2 a alth ar 27 is r trau		Yolanda E. Shanno	on/ Daughte	er 3005	Brodkin Av	e. Ft. V	Washingt	on, Md. 2	20744				
Baltimore,	permit. Pages 1 end 2 should be filed within Depertment of Heelih and Mental Hygiene. Importent: if item 27 is marked other than any injury or other traumatic event, ILA Magnes.		20a. Method of Disposition  † Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	Town, State										
Baltir	permit. P Depertme Importen any injur.		21. Signature of Funeral Service Lights											
		$\dashv$	21. Signature of Funeral Service Lightnese  22. Name and Address of Facility Alexander S. Pope Funeral Homes, P. A.  23a. Part. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  AC AND ACT OF THE PROPERTY											
100	Physician		shock, or heart failure List only one cause on each line.  Immediate Cause (Final disease or condition a. Stomach Cancer resulting in death)											
1	/Medical Examiner			Due to (or as a	consequence of):									
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or as a	consequence of):									
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c										
68760,	ificate be executed physicien and as the burial-transit	edicai Ex	resulting in death) Last	Due to (or as a	consequence of):									
P.O. Box	es that the death certifigned by the attending be detached for use a	Completed by Physician/M	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of de Month	elivery Day Year				
	requires that the een signed by th nould be detache	d by Ph	Part II. Other significant conditions co	entributing to death bu	t not resulting in the	underlying cause given	in Part I.			to the cause of death?  Probably 4 Hinknown				
ecor	w s s	npiete						24a. Was a autops	sv prior to	utopsy findings available completion of cause of				
E	The est	ပ္ပ						1 ☐ Yes	2.2√No 1 □ Ye	s 2 No				
Zi Z	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Other		h (Check only or						
to	문 = =	 7	1 Tes 2 No  27. Manner of Death	1 ∐ Inpatier 28a. Date of Injury (Month, Day	t 2 ER/Outpati	#IL 3   100 A	4 Li radi Sing Mo		ence 6 Other (Sp ow injury occurred	ecify)				
9	ding f th. : After funer	tion	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation		Year) Injury		s 2 No							
Division of Vital Records,	or Atter after dea Director	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State)											
	To the Hospitel or Attenwithin 24 hours after deatl Within 24 hours after deatl To the Funarel Director: completely filled in by the	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifier (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	within 2 To the comple	Me	29b. Signature and title of certifier	11		29c. License n			9d. Date signed (Mor	nth, Day, Year)				
			A wooder	/hlost	500	Hos	-5397	27 6	Detober	19,2006				
10	(10)		30. Name and address of person who s	empleted cause of de	ath (Item 23a) (Type 3 c 0 / Ho	spital I	25597 Dive,	Charle	Is MA	ryland				
	Sta Regist		31. Date filed (Month, Day, Year)  OCT 2 4 2000		r's Signature	udi-			Ur					

State of Maryland / Department of Health and Mental Hygiene UU b 1 - Stete Registrer Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month Day Year October 18, 2006 **Physician** Thomas David Rosen 11:10 аМ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Chevy Chase
If Under 1 Year If Under 24 Hrs. Montgomery 7505 Lynn Drive 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1☐ M 2□ F Yrs. Director May 6, 1955 362-62-7538 51 Michigan Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits of 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. 27 is marked other then "naturel", or iteme 23a or 28a-f show traumatic event, the Medical Exarcinatinatic event, the Medical Exarcinatinatic event. 1 ☐ Yes 2 No Directo Maryland Montgomery Chevy Chase 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7505 Lynn Drive 20815 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 Spec White 1 ☐ Yes 2 XNo Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Attorney Non-Profit Organization 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy important: if Item 27 is marked oth any injury or other traumatic event once. Be Geraldine DesRosier Harold Rosen 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7505 Lynn Drive, Chevy Chase, Maryland 20815 Hsiuchen Flora Tsui/ Wife 23, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition October 1 Bunal 2 Cremation 3 Removal from State 2006 Gate of Heaven Cemetery Silver Spring, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility.
Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the cleease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiralory arrest, shock, or heaft failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pancreatic Cancer 8 Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury Due to (or as a consequence of) Examiner been signed by the attending physicien and should be detached for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an cate hes page 2 s autopsy performed? 1 Yes 2 No : After this certifical funeral director, or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 1 Natural 5 Pendina deeth. 1 Tes 2 No investigation 2 Accident the Director 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or At within 24 hours attar or To the Funeral Direct completely filled in by 4 Homicide 29a. Certifier to Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D23308 myamo October 19, 2006 12 of person who completed cause of death (Item 23a) (Type, Print)
ego, M.D 6420 Rockledge Drive, #4100, Bethesda, MD 20817

State Registrar

State of Maryland / Department of Health and Mental Hygiene 35853 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month **Physician** 10:02 PMM OCTOBER 19, 2006 HARVEY ROSENBERG /Medical 4c. County of Death 4b City Town or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner SILVER SPRING MONTGOMERY HOLY CROSS HOSPITAL If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1∰M 2□F Months Days Hours Min. Yrs. Director JUNE 14, 1953 WASHINGTON, D.C. 217-44-2855 Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or iteme 23a or 28a-f show the Medical Examiner must be notified at NORTH BETHESDA TYPes 2 No Director MARYLAND MONTGOMERY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 5701 LUXEMBURG STREET #303 20852 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🗷 No 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 ☒ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) "NONE" "NONE" 4 other permit Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any injury or other traumatic event, 900s. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be EVA MOSTOW SIMON ROSENBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 701 FALLSGROVE DRIVE #411, ROCKVILLE, MD JERRY POSTAL/BROTHER-IN-LAW Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 X Removal from State KING DAVID MEML GDNS 10/22/2006 FALLS CHURCH, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, 20852 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician aRESPIRATORY FAILURE /Medical Due to (or as a consequence of): Examiner CHRONIC LYMPHOCYTIC LEUKEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physicien Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tyes 2 No 3 Probably 4 ⊠Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No 1 Yes 2 🛭 No 1 Tyes Physician: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🕅 Inpatient မှ 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10/20/06 H0064588 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOLIA, ASHISH KISHORE DO, 1500 FOREST GLEN ROAD, SILVER SPRING, MARYLAND 20910 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2006 OCT 23 Registrar

		_ For	State of Ma		d / Depa	artment	of Hea	alth and	•		•	35854	
		1 - State Registrar			Cer	tificate	of De	eath		Reg. No	. 000	00004	
Physic		1. Decedent's Name (First, Middle, Lat.	SI)						2. Date of D Month	eath Da	y Year	3. Time of Death	
/Medi Exami		4a. Facility Name (If not institution, give	street and number)			4b. City, T	Town, or Lo	cation of Deat		40	. County of Death		
		Habeen 1	Lane			Ros	12.14	L		0	Mondgomes		
Funeral		5. Social Security Number 6. S	ex 7. Age	e (In yrs.	last birthday)	If Under	1 Year If	Under 24 Hrs Hours Min.		rth	9 Birth	place (State or Foreign	
Director		124-09-6939	□M 2X0F	93	Yrs.	WOTHIS	Days	TOUTS WINT.			1913 F		
pu s		Usual Residence of Decedent  10a, State 10b. County		10c Cit	v. Town or Lo	cation						10d. Inside City Limits	
eho!	5				.,	Cation						1 X Yes 2 □ No	
the A	Director	MD Montgome	ery	Roc	kville	10f. Zip	Codo			100 0	tizen of What Cor		
with				2122								mury :	
ne 23	Funeral	6105 Montrose Roa	12. Was Decedent I		.S. 13. V	2085		anic Origin? (S	pecify Yes or N	U.S	14. Race - Amer	ican Indian.	
ritter o	F	1 ☐ Never Married 2 ☑ Married	Armed Forces?  1 Yes 2 The lift Yes, Give	lo.					pecify Yes or N o Rican, etc.)		Black, White	, etc.	
oris e	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give 25 Year or Dates:			1 ☐ Yes 2	No S	Specify:			Specify: Wh	ite	
Maryland 21215-0036 d 2 should be filed within 72 hours efter deeth with the Maryland th and Mental Hygiene. The marked other then "natural", or Iteme 23s or 28s-f show traumatic event, tra Madical Exama er must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	fucation		16a. Deced	ient's Usual	Occupation	n na most of wo	rkına	16b. K	(ind of Business/l	ndustry	
Ly ithin	hdu	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. L	DO NOT us	e retired)	ng most of wo	9				
led w		12			Homema	ıker_	T				Home		
€ dag 5	Be	17. Father's Name (First, Middle, Last)					18	. Mothers Nai	ne (First, Middle	a, Maider	n Sumame)		
laryland 21215-0036 2 should be filed within 72 hours efter deeth with the Marylan and Mental Hygiene and Mental Hygiene ie marked other then "natural", or fleme 23s or 28s-f show aumatic event, the Madical Example arms to modified at	ပု	Max Isman  19a. Informant's Name/Relationship (	Firm a Deinet		10h Mailie				nobtain		,		
Man d 2 sl th an 7 ie r		Solomon Rubin - hu	***								or Town, State, Z		
Ore, Maryla ges 1 end 2 should t of Health and Men if I tem 27 le marke or other traumatic		20a. Method of Disposition	isballd	20b. F	6105 M	sition /Nam	e of		RO-		11e MD		
nor of int of in		1 ☑ Burial 2 ☐ Cremation 3 ☑ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	St	emetery, cren ar of I	natory or ot avid	her place) Cem.	10/2	3/2006		Lauderda		
Baltimore, Misperimere, Misperiment Peges 1 and 2 Department of Health important: if them 27 is any injury or other transcens.	1	21. Signature of Funeral Service Licer			22	. Name and	1 Address o						
Daa Permii Depermii Impou		LAND D			I	anzan	sky-G	oldber	g Memor	ial (	Chapels,	Inc.	
		23a. Part1. Enter the disease, or com	plications that caused	the deat				11e Pi			ville, M	Approximate	
Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each lir	10.								Interval Between Onset and Death	
/Medical		disease or condition resulting in death)	a. Due to (or as		uence of):								
Examiner			140	- 1	2/10								
	De	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	Due to for as	a consec	vence of):								
760, te be executed ysicien end e buriai-transit	Examiner	that initiated events	O. D. Terris	0	200	- 200		1	S 40 (	3500	ر کجیرح		
760, e be exe rsicien e e burial-l		resulting in death) Last	Due to (or as	a conseq	uence of):				1		,		
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Box 687	Physician/Medi	IF FEMALE:	00 4				-7/-3						
Box eeth cert ettending for use	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Feta	Il death 3	Ectopic pre					23d. Date of deli-	very Day Year	
the e	ysic	1 ☐ Yes 2-☐ No 9 ☐ Unknown	4☐Pregnant at 9☐ Unknown	time of d	leath 5 L	Other (spe	ecity)						
of Vital Records, P.O. Box 68 Physician: The law requires that the deeth certifica this certificate has been signed by the ettending ph rail director, page 2 should be deteched for use es th	H.	Part II. Other significant conditions of	ontributing to death b	ut not res	ulting in the u	nderiving ca	iuse given ii	n Part I.	23e. Did	tobacco	use contribute to	the cause of death?	
Division of Vital Records, P.O. to attending Physicien: The law requires that the datter death.  Director: After this certificate has been signed by the lin by the funeral director, page 2 should be deteched	d by	3/2 heimer		_			•		1 🗆	Yes 2		bably 4 Unknown	
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Re la he la he s	Ę.								auto		prior to c death?	ompletion of cause of	
In: T	ပိ	25. Was case referred to medical					26	Class of De	1 ☐ Yes		1 ☐ Yes	2 No	
/siciu	ToB	examiner? 1-2 Yes 2 □ No	Hospital:	int 2	ER/Outpatien	t 3□ DO	100		110000000000000000000000000000000000000		6 ☐Other (Spec	efu)	
g Physer this	ı.	27. Manner of Death	28a. Date of Inju (Month, Da		28b. Time of		3c. Injury at Work?		28d. Describe			7	
VISION Attending r death. ector: Aftei by the fune	atio	1- Natural 5 Pending 2 Accident investigation		y rear,	Injury	м		2 □ No					
VIS	Certification;	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Injuding, et	ury - At h	ome, farm, str	eet, factory,	office		28f. Location City or To			ral Route Number,	
District or safte	Se		Ballating, or	J. (OP 00					0.0, 0.	, 5,0	_		
Division of Vital Records, P.O.  To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director. page 2 should be deteched	edical	29a. Certifier   (Check only 2   Medical Example 1.2 Medical Exam	ysician: To the best niner: On the basis of	of my kno	owledge, death	n occurred a	it the time,	date and place	e, and due to the	cause(s	and manner as	stated.	
the hin 24 the f	Med	one)	and manner sta	ited.									
	-	29b. Signature and title of certifier	Diffen	>			License nu				ate signed (Month		
2			1								112/5000		
		30. Name and address of person who	completed cause of d	eath (Iter	n 23a) (Type,				Ster so-				
Ç.	ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	ature _		Lith	مارات	wo	'دل	129		
Regist		OCT 2 3 20	16	H	Some	Ke 3							

State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Nov 4, 2006 Keith Rinehart /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 10825 Mexico Farms Road Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Apr 11, 1940 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 XM 2 ☐ F 218-38-2352 66 Yrs. Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits rthen "natural", or Items 23a or 28a-f shov the Medical Examinar must be notified at MD Allegany Cumberland Director 1 ☐ Xes 2 ☐ No 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? 10825 Mexico Farms Road 21502 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: Specify: white þ 3 Widowed 4 Divorced 1960-64 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry i Hygiene. other than " College (1-4or 5+) Freight Conductor Chessie Railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental h Darl Rinehart Thelma (Cole) Rinehart b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10825 Mexico Farms Rd Cumberland MD 19a. Informant's Name/Relationship (Type, Print)

Janet Rinehart wife MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ₽ 1 Burial 2 Cremation 3 Removal from State Rocky Gap Veterans' Cemetery = 5 Department of Important: If eny injury or soce. 11/8/2006 **Flintstone** MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signation of Funeral Service Licensee 22. Name Scarpelli Funeral Home, P.A. 108 Virginia Avenue; Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsetjand Death Immediate Cause (Final disease or condition resulting in death) WIESCH TAR **Physician** UNG /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Examine The law requires that the death certificate be executed anding physicien and use as the burial-transit Due to (or as a consequence of): Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) ned by the a e detached f 1 ☐ Yes 2 ☐ No P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ been signe should be 2 No 3 Probably 4 □Unknown Completed 1 ☐ Yes 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 certificate 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation I Director: / 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \( \text{Homicide} \) hours after within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signatury and title of contifier 29d. Date signed (Month, Dev. Year) D31875 OBEST 30. Name and address of person who opeted cause of death (Item / 3a) (Type, Print) 904 Seton Drive Cumberland MD 21502 Robert Welik M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 3 2006 Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35856 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Day **Physician** 7:20 AM STEWART A. RICE, JR. 31 200€ DCT /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Bultimane University hospital specilty If Under 1 Year Months Days If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 2/4/194 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) 9. Birthplace (State or Foreign **Funeral** Months Hours 19∑ M 2 □ F Maryland 212-50-7182 59 Director Usuel Residence of Decedent 10h County 10c. City, Town or Location 10a Stete 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryle Department of Heath and Mental Hygiena. Important: If Item 27 is marked other than "natural", or items 23s or 28s-4 show any injury or other traumetic event, the Modical Examiner must be notified at Darlington 1 ☐ Yes 2 ☑ No Harford Funeral Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 21034 3711 Berkley Road 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) State Highway Roadworker 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Carrie Isabel Booker Stewart A. Rice, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3711 Berkley Road, Darlington, MD Alice Rice/Sister
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 11/6/06 Delta, PA Trinity Zion Cemetery 4 Donation 5 □ Other (Specify) 21. Signat r of Funeral Service Licenses 22. Name and Address of Fecility Harkins Funeral Home, Inc., Delta, FA 17314 se, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. art1. Ther the diseas shock, or heart fail te. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical 1.5 45 encephalipathy Anoxic Examiner Due to (or as a consequence of) 11 Examiner Cardiapulmonary awest The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 15 lps Hypertonsion by Physician/Medical Due to (or as a consequence of): mellimi Diobetis 23b. Did tobacco use contribute to the cause of deeth? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Onknown serzhies, rend dellare on Chrome 24b. Were autopsy findings available prior to completion of cause of death? Chrmie obstuctie Long diseuse 24a. Was en eutopsy performed? Hancollalysis, Completed Rospiratory youline ventilator depondent 21 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was cese referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Plece of Death (Check only one) Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To this within 24 hours aftar death.

To the Funeral Director: After this completaly filled in by the funeral 28e. Date of Injury (Month, Dey Year) 28b. Time of Injury 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D36494 11-3 1000 KNESHIMO 3 30. Neme end address of person who completed cause of death (Item 23e) (Type, Print)

**DHMH 16 Rev 6/95** 

State Registrar KDES Almo

31. Date filed (Month J

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2006

32 Registrar's Signature

Division of Vital Records, P.O. Box 68760,

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	æ		Registrar  1. Decedent's Name (First, Middle)	Last)			imodio	0. 0	Julii		2 Date of De	ath	UUD	3. Time of Deat	h
	Physicia /Medic		Claude	Eugene	Rowa	n			Sr.		Nov 6,	2006	Year	6:40 am	М
	Examin		4a. Facility Name (If not institution,	•	nber)		4b. City, Tov			f Death		4c. County of Death			
			520 Broadway C		7 4 - 4 - 4 - 4 - 4 - 4	at- 4- 1	Cumb		and If Under 2	04 Hrs	Allegany				
	Funeral Director		5. Social Security Number 220-10-0552	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs, last birt.	Yrs.		ays	Hours	Min.	8. Date of Birth (Month Day Year) Feb 6, 1918			nplace (State or Ford MD	aign
4			Usual Residence of Decedent						1						
	arylan show d at	_	MD Alleg	anv	10c. City, Town		erland						10d. Inside City Limits 11☑ Yes 2 □ No		
	Ba-f	ecto										10= Citi	Og. Citizen of What Country?		
	with the or it	Funeral Director	10e. Street and Number 520 Broadway C	ircle			101. Zip Co		1502			USA			
	me 23	era	11. Marital Status	12. Was Dece	dent Ever in U.S.	13. V	Vas Decedent				cify Yes or No Rican, etc.)		Race - Ame		
9	atter deeth with the Marylan or Iteme 23a or 28a-f show infinet ment be notified at	Fur	1 Never Married 2 Marri	Armed For 1 Yes If Yes, Giv	2 🗆 No	1	Yes, specify		, Mexican Specify:	, Puerto I	Rican, etc.)		Black, White		
003	72 hours after deeth with the Maryland 'natural', or Iteme 23s or 28s-f show Jigal Examinal must be notified at	d by	3. Widowed 4 □ Divorced	Year or Da	ites: VV 7 VII								oecify: whi		
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g	at Hygin f other vent, I	Bec	17. Father's Name (First, Middle, L			_					(First, Middle	, Maiden Su	rmame)		
ylaı	should be nd Mental marked o	To:	Christopher R						Viol		lowan				
Baltimore, Maryland 21215-0036	d 2 h a 7 le		19a. Informant's Name/Relationsh Theresa Rowan		ughter 2	. Mailin	g Address (Si Willow	Ter	race	r or Rura	Sterli	өг, City or T <b>ng</b>	own, State, Z	<sup>(ip Code)</sup> 20164	
J.	of Health of Health f Item 27		20a. Method of Disposition 1 ØBurial 2 ☐ Cremation	2		у, сгел	natory or other	r place,			ate	20c. Loca	tion - City or		
Ē	Pag nent ant: I ury o		4 □Donation 5 □Other (Sp	ecify)	Rocky G	Sap \	Veterans	Ce	meter	y	11/8/2006	Flints	stone	MD	
Balt	permil. Pag Department Important: I eny injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Home, PA Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD											2	
			23a/ Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, intersection on each line.  Appropriate the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, intersection.												
	Physician		trimediate Cause (Final disease or condition	_aC	ONGESTI	VE	HEA	MI	- FA	4164	RE		cil	Onset and Death	w
	/Medical Examiner		resulting in death)	Due to (	CANCESTI or as a consequence CROHARY	of):	11	112	Λ	100	110			U	
, t.		-e	Sequentially list conditions,	b. Due to (	or as a consequence of	of):	1714 121	7		10 E	かた				
E	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					,							
oʻ	an any	Еха	resulting in death) Last	CDue to (	or as a consequence of	of):									
8760	cate be executed physician and the burial-transit	dical	W.	d											
9	entification plants of the second	Med	IF FEMALE:	220 If you out	name of programmy										
Вох	eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live b	come of pregnancy inth 2 Fetal death ant at time of death		Ectopic pregr					230	d. Date of del Month	very Day Year	
o.	that the de led by the a	ysk	1 □ Yes 2 □ No 9 □ Unknown	9□ Unkno			701.01 (5,000)	.,,							
ds, P.	S 5.0	þ	Part II. Other significant condition  VALVULA	ns contributing to de	eath but not resulting in			se giver	n in Part I.			obacco use Yes 2□!		the cause of death	
Sor	w requir been si should	lete	CHRONICO	SRITA	uet IVE	LU	NG 7	1100	EASE	•	24a. Was	an a	24b. Were au	topsy findings availa	able
Vital Records,	The lay te hes age 2	Completed	<u></u>					- 110			auto perfo 1 ☐ Yes	psy ormed? 2 No	prior to death?	completion of cause	of
ital		BeC	25. Was case referred to medical examiner?						26. Place	of Death	(Check only			20110	
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	ding Ph After th funeral	inol:	27. Manner of Death  Natural 5 ☐ Pending			Time of njury		Work?			28d. Describe	how injury o	occurred		
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Οį	all or A	Certification:	4  Homicide determi		ng, etc. (Specify)	,	001, 1401019, 01	,,,,,,			City or To	wn, State)			
	To the Hospital or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	edical C	29a. Certifier 1 Certifyin (Check only 2 Medical I	g Physician: To the Exeminer: On the ba and mann	best of my knowledge asis of examination and ner stated.	e, death	occurred at t vestigation, in	the time	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s) ar date and pl	nd manner as ace, and due	stated. to the cause(s)	
	within To the	Me	29b. Signature and title of certifier				29c. L	icense	number			29d. Date signed (Month, Day, Year)			
	4		> Itsidh	ve			T	$\binom{9}{r}$	169	DM	'	No	5.6	2001	)
	3		30. Name and address of person	who completed caus	e of death (Item 23a) (	(Type,	Print)		0	, ()	a.	1 . 1	.000	0.00	
100			31, Date tila (Month, Day, Year)	4/11/1	egistrar's Signature	hy	pull	Sh	Tid	jU	umber	and	YYII)	21503	
33 14 14 15	Sta Regist		NOV 1 3		Surar S Signature	5-3-1	resi								

State of Maryland / Department of Health and Mental Hygien@ [] [] 5 35858 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Smith October 22, 2006 Gertha 7:25 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Bradford Oaks Nursing Home Clinton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) A1 aboves 8. Date of Birth August 12, 1921 7. Age (In yrs. last birthday) 5. Social Security Number Funeral 1 □ M 2 X F 85 Alabama Director 095-22-8430 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a. State 10b. County ir than "natural", or items 23s or 28s-f ahow If e Madical Examiner must be notified at 1 ☐ Yes 2 No Prince George's Ft. Washington Maryland Directo 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 20744 6801 Border Place USA Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 20No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ŽX No Specify: Specify: Black Be Completed by 3 ∰idowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker In Home of Health and Mental Hygie fitem 27 is markad other r other traumatic evant, III 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is markad othi any link or other traumatic event once. 17. Father's Name (First, Middle, Last) Paul Slaughter Venie McCord ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6801 Border Place Ft. Washington, Maryland Jacquelynne C. Woolfolk / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 10/26/2006 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Highland Mem. Gardens Bessener, Alabama 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signature of Funeral Service Licensee alu 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Antavio scleratio Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examine physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as attending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ AIZHeimer 1 Yes 2 No 3 Probably 4 Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No this certificate Division of Vital To the Hospital or Attanding Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 Wo After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death. within 24 hours after death To tha Funaral Diractor: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCTUBE 22 DUG 11701 avigh Rood, Fat Washington, unarylone 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tomad un Mim 32. Registrar's Signature 31. Date filed State Registrar

State of Maryland / Department of Health and Mental Hygiene [] [] [ 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Lillian Stewart 11:38 23, October | 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. Aug 23, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 1 M 2 KF 578-28-6621 Director 83 1923 Washington, Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Director Maryland Prince George's Capital Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4716 Gunther Street 20743 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 █No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: <u>ک</u> Specify 3 XWidowed 4 ☐ Divorced ear or Dates White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8th College (1-4or 5+) Homemaker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vincent Richardson Agnes Thompson 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Stephen Baker (Nephew) 1124 Elfin Avenue, Hillside, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Washington National 4 ☐ Donation 5 ☐ Other (Specify) 10/27/2006 Suitland, MD 21. Signature of Pineral Service Licenses 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd.Lanham, MD 20706 23a. Part. Enter the disease, or compositions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List any one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) C000 Physician /Medical Resuscitation Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physicien and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No 1 Yes 2 No After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Anatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 24 Oction Ob D00641155 h woon 14 Eric McDonald, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 000 Clinton M 417 1974 Surratts 7503 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

OCT 2 8 2006

State of Maryland / Department of Health and Mental Hygien [ ] 35860 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician JULIET SCHWARTZ 11:25 A M October 26, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Valley Rd. 7. Age (In yrs. last birthday) 2666 Brook Frederick Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
June 24,1917 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛱 F Yrs. Director 109-09-1970 89 New Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10c. City, Town or Location 10a State 10b Counts 10d. Inside City Limits 77 is marked other than "natural", or itame 23a or 28a-f ahow traumatic avent, the Modical Exercitor most be notified at 1 Yes 2 □ No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2666 Brook Valley Rd. 21701 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 💢 Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 No Specify: white Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales - Retail clothing store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental h Samue1 Krakow Regina Ginsberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health at Important: If item 27 is any injury or other trai once. Schwartz Leo / Husband 2666 Brook Valley Rd. / Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Frederick Crematory 10/28/2006 Frederick, Maryland 21. Signature of Funeral Service Lip-nsee 22. Name and Address of Facility Stauffer Funeral Home selesson 1621 Opossumtown Pike/ Frederick, MD 21702 23a. Part1. Offer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia e Cause (Final Physician Due to (or as a consequence of): cancer disease or condition resulting in death) yeas /Medical Examiner Sequentially list conditions, if any, leading to important cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires thet the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 pronths?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should I Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) ierel Director: After th 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Dire 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D00515 Clun minhour mo 30. Name and address of person who compfeted cause of death (Item 23a) (Type, Print) 32 flegistrar's Signature Washington DC 20307 Ellen Sinholt 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

OCT 3 0 2006

State of Maryland / Department of Health and Mental Hygiene For State Registres Certificate of Death 3. Time of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) **Physician** 12:40 PM October 20, 2006 Audrey Mae Shipp /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery <u>Bethesda</u> Manor Care- Bethesda 8. Date of Birth (Month, Day, Year) April 21, 1 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 ☐ M 2 🖾 F 77 1929 578-34-3112 Yrs. Maryland Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State item 27 is marked other then "neturel", or items 23e or 28a-f show other treumstic event, the Medical Examinar must be notified at 1 Yes 2 No Director Rockville Maryland Montgomery 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number filed within 72 hours after death with 5550 Tuckerman Lane, #541 20850 Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White atimore, Maryland 21215-0036 3X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Writer/Editor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental P should be Ella Covell William H. Collins ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 1401 N. Kenilworth Street, Arlington, VA 22205 item 27 David C. Shipp/ son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of P Importent: if its any injury or ot once. October 27 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 2006 Parklawn Memorial Park Rockville, Maryland 21. Signature of Funeral Service Licensee Francis Address Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 dans 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** END STAGE DEMENTIA /Medical Due to (or as a consequence of): Examiner THRIVE FAILURF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner certificate be executed Due to (or as a consequence of) burial-Box 68760. ician/Medical the as IF FEMALE 980 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 Yes 2 No ģ 4☐Pregnant at time of death 5 Cther (specify) Ö detached 9 Unknown Physi 9 Unknown ģ ۵. signed t 1 be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Be 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖵 NO P 1 Yes filled in by the funeral dir this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: After Injury Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 Homicide 50 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 20125101 D0057124 - , MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 Medical Center Dr., # 201 Rockville, MD 20850 Truang Bao, M.D 31. Date filed (Month, Day, Year) 32. State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** ам Frieda Schaffer 20, 2006 7:40 October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 509 Leighton Avenue Montgomery Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Yrs Director 064-09-1968 94 June 21, 1912 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits woye ns 23a or 28a-f shov 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10g, Citizen of What Country? 10f Zin Code 10e. Street and Number 509 Leighton Avenue 20901 USA Funeral death 14. Race - American Indian, Black, White, etc. or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Hygiene. other then "natural", or item ent, the Madical Exemples. Pages 1 and 2 should be filed within 72 hours after enen of Health and Mertal Hygiene. enen if Item 27 le marked other then "natural", or ite ary or other treumatic event, the Madical Essimins 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: by Specify: White 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teacher University of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Katherine Fronehur Stephen Winkler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia S. Crawford / Daughter 1309 Magnolia Road, Silver Spring, MD 20905
Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | 20c. Location - City or Town, State 20a. Method of Disposition Depertment of H Importent: If Ite eny Injury or ot once. Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) October 27 Gate of Heaven Cemetery 2006 Silver Spring, Maryland 21. Signature of Funeral Service Licensee Francis of Address of Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 CMP2 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Congestive Heart Failure
Due to (or as a consequence of): 4 Months /Medical Examiner Hypertension years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Hyperlipidemia vears Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Year Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed t Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performed? certificete 1 ☐ Yes 2√No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To After th 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospitel or At within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide 29a. Certifier 1 环 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis-of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner, stated. Au 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) October 23, 2006 uastra 368/6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marsha Seidelman, M.D. 10301 Georgia Avenue, #304, Silver Spring, MD 20902 31. Date filed (Month, Day, Year) 32 Registrar's Signature State ( NOOSE Registrar 2006

State of Maryland / Department of Health and Mental Hygienes 35863 Certificate of Death Reg. No. 2 Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) October Physician 11, SHAW 11:34 Рм **HOPE** Η. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Prince George's Stitland 2004 Porter Avenue If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1□ M 2√F Yrs. 579-36-2790 77 16, 1929 Washington, D.C. Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location Suitland 10a State 10b. County Prince George's Maryland 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or itema 23a or U.S.A. 2004 Porter Avenue 20746 Funera permit. Pages 1 and 2 should be filed within 72 hours after deat. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than any Injury or other traumait. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Statistician Federal Government 12th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lincoln Mills Anna Mae Batten 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2004 Porter Avenue, Suitland, Maryland 20746 Clarence W. Shaw (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method ol Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal Irom State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans' Cemetery October 19, 2006 Chelterham, Maryland 22. Name and Address of Facility Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Stroke Months /Medical Due to (or as a consequence of) Examiner **Hypertension** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🟋No Month Year Day 4 Pregnant at time of death 5 Other (specify) signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an page 2 s autopsy rmed? 2∐No certificate 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 2 1 ☐ Yes 2XNo 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral dir 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? 1 X Natural 5 Pending 1 Tes 2 No investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00039691 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4467 Old Branch Avenue Suite 201 Temple Hills, Md. B. Redjaee, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 23 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day **Physician** Shellia Elizabeth Stroman 18, 2006 /Medical October 8:45A 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital

5. Social Security Number 6. Sex Silver Spring Montgomery 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) (State or Foreign **Funeral** Days 1 □ M 2 🕱 F 45 Director 218-78-3699 June 25,1961 Wash..DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Md. PG Upper Marlboro 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 10115 Scotch Hill Drive 20774 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. þ 3 Widowed 4 Divorced Black Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Cafeteria Worker</u> Board of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wesley Atkins Altee E. Thurston 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2716 Lorring Drive #202 Kiana S. Harley/daughter District Heights,

20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem. 10/28/06 | Clinton, Md. 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signatur of Funeral Service Licenses 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cerebral Anoxia 5 Days /Medical Due to (or as a consequence of): Examiner Gastrointestinal Bleed Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 5 Days Examiner Due to for as a consequence of The law requires that the death certificate be executed Due to (or as a consequence of) ivision or Vital Records, P.O. Box 68760, nding physician Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death Day Year 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably X ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No autopsy 2**X** No 1□ Yes I or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2X No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D52503 October 18,2006 30. Name and address of person wind pleted cause of death (Item 23a) (Type, Print) Shailesh Sheth, M. D. 1500 F 31. Date filed (Month, Day, Year) 32. Registrar's Signature 1500 Forest Glen Rd., Silver Spring, Md. 20910 31. Date filed (Month, Day, Year) State DCT 23 2006 Registrar

State of Maryland / Department of Health and Mental Hygieney Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician :51 PM October RUBY ANN STARLING /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner George's Prince Lanham Doctor's Community Hospital If Under 1 Year Months Days If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. 1 □ M 2 1 F Hours Yrs. 83 30, Maryland Aug. Director 579-18-4246 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h County or itams 23a or 28a-f ahow the Medical Exercicer must be notified at 1 X Yes 2 □ No Directo Maryland Prince George's Hyattsville 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 20781 U.S.A. 5601 Hamilton Street Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) other than Elementary/Secondary (0-12) U.S. Government 12 Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 12 should be fi h and Mentel H 7 Is marked of Horace Elder Murphy Annie Ruby Padgett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If itam 27 Is any injury or other trau 5601 Hamilton Street, Hyattsville, MD 20781 William L. Starling Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10/18/2006 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licensee 4739 Baltimore Ave., Hyattsville, MD 20781 11/11/10 234. Part 1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed physicien and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical the Se IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death esn 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day signed by the atte 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 1 ☐ Yes 2 X No 1 ☐ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ Impatient 2 ☐ FR/Outpatient 3 DOA this After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; Injury 1 Atlatural 5 Pendina 1 Tes 2 No death. investigation 2 ☐ Accident Diractor: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d, Date signed (Month, Day, Year) 29b. Signature and to of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14212 Bradshaw Drive, Silver Spring, MD 20905 Antiono B. Valentin, MD 31. Date filed (Month, 82. Registrar's Signature State Registrar

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		1. Decedent's Name (First, Middle, La	st)							2. Date of D Month		Day	Year	3. Time of	Death
Physici /Medio		Garrett			San	ders	on			Oct.			1 dai	2:00	A.M.
Examir		4a. Facility Neme (If not institution, giv	e street and nu	ımber)		4b. City	, Town, or	Location of	of Death			4c. County	of Death		
		Manor Care					Potor	nac				Montg	omer	У	
Funeral Director		5. Social Security Number 6. S 097-22-3577	ex Mi 2□F	7. Age (In yrs. 77	last birthday) Yrs.	If Unde Months	Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, P Jan • 24	irth ay Ye	)29	9. Birthp Cour New	olace (State of try) York	Foreign
D .		Usuel Residence of Decedent													
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<u> </u>	by Funeral Director	11. Marital Status 1 □ Never Married 24⁄2 Married	Armed F	2 🗌 No		Was Dece If Yes, spe 1 ☐ Yes	ecify Cuba	ispanic Ori in, Mexicar Specify:	n, Puerto	ecify Yes or N Rican, etc.)	0-	Blac	- Americ k, White, : Whi		
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		Virginia Daly San	nderson							ashing	-				
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Pages Pages ment of ant: If it ury or o		4 □ Donation 5 □ Other (Specif		Me	tropol:	itan	Crem	atory	, Oct	.20,06		Alexa		a, Va.	
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	/Me	IF FEMALE:	23c. If yes, ou	itcome of pregna	ancy							23d Dat	e of delive	20/	
BOX Bath cer attendin tor use	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Fete	el death 3	Ectopic p	oregnancy					Mor		•	'ear
by the darkached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unkr		16atii 5_	10(1)61 (3	peciiy)								
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pital		29a. Certifier 1 Certifying Pl	Vsician: To 45	a hast of my ka	wiedre doct	h occurre	d at the tim	ne date an	nd place	and due to the	9 (2112	ea(s) and ~-	000122	tated	
DIVISION OT VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely tilled in by the tuneral director.	Medical	(Check only 2 Medical Examone)	niner: On the b	basis of examination of the state of the sta	ation and/or in	vestigatio	n, in my o	pinion, dea	th occurr	ed at the time	, date	and place, a	ind due to	the cause(s)	
o the o the omple	Me	29b. Signature and title of certifier	^			29	c. License	e number	· · · · · · · · · · · · · · · · · · ·		29d.	. Date signed	(Month,	Day, Year)	
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10		30. Name and address of person who	completed car	ise of death fitor	n 23al (Type	Print\	כע	1313				JCCODE	- 10	, 2000	
		Loreto S. Albiol		-		,		ui to	305	Retho	040	ьма	2001	1/2120	2
Çt.	ate	31. Date filed (Month, Day, Year)	32.4	Registrar's Signa	ature	1100		416	505,	Derne	oua	۰ ۱۹۵۰ و د	2001	14-217	)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) <sup>Day</sup> 2006 Month **Physician** 18, G. Oct. Tvanhoe 11:50 A M Seixas /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** 1**X** M 2□ F 262-44-4458 92 Director Aug. 19, 1914 Panama Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State r 28a-f sh notified a TX Yes 2 No Director Md. Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 2 and 10 luy or other traumatic event, the Medical Examiner must be nonee. U.S.A. 207 Twisted Stalk Drive 20878 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 □ No Specify: Panamanian Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 'Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Procurement Officer Dep't of Justice 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Seixas Angela Acebo မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemary Reid/Daughter Twisted Stalk Dr., Gaithersburg, Md. 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. Oct.24,06 |Silver Spring, Md. 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Eun 1 Service I rennee 2222 Wisconsin Ave., NW., Washington, DC 20007 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** Alzheimer's Disease /Medical Due to (or as a consequence of) Examiner Aspiration Pneumonia Sequentially list conditions Due to lor as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Congestive Heart Failure nding physician and use as the burial-tran Due to (or as a consequence of) Physician/Medical Sepsis IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Malfunction of feeding tube 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Dysphagia autopsy performed? res 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐XNo 1 Mnpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1X Natural 5 ☐ Pending investigation

The law requires that the death certificate be executed P.O. Box 68760, Division or Vital Records, To the Hospital or Attending within 24 hours after death. within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

the Maryland

Baltimore, Maryland 21215-0036

Certification: To

Medical

2 Accident 3 ☐ Suicide

29a. Certifier

4 Homicide

6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

M COAN

D01191

29c. License number

29d. Date signed (Month, Day, Year)

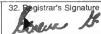
Oct. 18,2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ralph M. Coan, M.D., 9618 Culver St., Kensington, Md. 20895

Registrar

31. Date filed (Month, Day, Year)





State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day **Physician** OCTOBER 20, 2006 DAVID HERMAN SCHLAGS 4:15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CASEY HOUSE-MONTGOMERY HOSPICE ROCKVILLE MONTGOMERY 8. Date of Birth
(Month, Day, Year)
JANUARY 30, 1924 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 10XM 2□ F 82 Yrs. NEW YORK 123-14-4688 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r then "natural", or iteme 23a or 28a-f ehow the Medical Examinar must be collified at 1 ☐ Yes 2 ☑ No MARYLAND MONTGOMERY SILVER SPRING Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3112 GRACEFIELD RD. #524 20904 U.S.A. Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married attimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: WHITE þ Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 SALESMAN MEN'S WEAR other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental SCHLAGS MOSKOWITZ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) = t: If item 27 7202 RHODE ISLAND AVENUE, COLLEGE PARK, MARYLAND 20740 LESLIE SCHLAGS MONTROLL/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If its any injury or of once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT. LEBANON CEMETERY 10/24/2006 ADELPHI, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, 23a. Part1. Enter the disease, or complete lines that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician HEPATOCELLULAR CARCINOMA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending for use as IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) , the 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by d be detact Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 XUnknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has performed? 1 Yes 2 X No 2 No After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 🗵 Other (Specify) HOSPICE ۵ 1 ☐ Yes 2 ☐XNo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 🖾 Natural 5 Pending 1 Yes 2 No investigation I Director: / 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medicai (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) enene rocks · mi D0064615 OCTOBER 25, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GENEVIEVE WROBLEWSKI, M.D., 6001 MUNCASTER MILL ROAD, ROCKVILLE, MARYLAND 20855 31. Date filed (Month, Day, Year) 32 Registrar's Signature State OCT 23 Registrar

State of Maryland / Department of Health and Mental Hygiene) 35869 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Ctober **Physician** 8 2006 MM5 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4b. City, Fown, or Land Company of the Company of t Examiner River Dital Center rest ex 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** , 1923 Vi country ia 1 ☐ M 2 🖾 F 219-42-3013 83 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f ahow the Medical Examinar must be notified at 10d. Inside City Limits Chestertown Director MD. Kent 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21620 USA 116 Woodstock Road s filed within 72 hours after death v I Hygiene. other then "natural", or Items 23e 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 ⊠ Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Gov't. Practical Nurse 8 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any lighty or other traumatic event, page. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lacy Ward Campbell Myrtle Moran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2117 Hallmark Drive, Gambrills, Maryland 21054 Sylvia Cord - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10-21-06 Ft. Lincoln Cemetery Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 N.W. Crain Hwy., Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician CANDIORUSPINATORY ARMUST MIRUTOS /Medical Due to (or as a consequence of): Examiner RUTTUM WITH PUNITONITIC PENFORATION DATI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE: 950 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetaf death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) the δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ + WICCORATION 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been signated 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wasan has page performed certificete the Hospital or Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient this 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred After t 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) ŧ, 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D52487 OTORON unn 18,2006 30. Name and address of person wild completed cause of death (Item 23a) (Type, Print) 400 South Cross St., Chestertown, Maryland 21620 Paul R. Johnson MD, 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar 0 2006

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State of Maryland / Department of Health and Mental Hygiene 7 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 10/30/2006 **Physician**  $A^{M}$ Lawrence Alfred Smith Sr. 12:10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Homewood at Crumland Farms Frederick Frederick If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**∑**M 2□F Yrs. 183-09-6963 90 Director 7/7/1916 PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ul Hygiene, . other than "naturel", or Items 23s or 28s-f ehow vent, Ibs Modifical Expandrer count be notified at 1 Yes 2 KNo Directo Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8817 Yellow Springs Road 21702 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No
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Year or Dates: WW II 1 ☐ Never Married 2 N Marned 1 ☐ Yes 2 X No Specify: Specify: δ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Potomac Edison Company 12 Lineman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be finand Mental Prince I marked of Edward Smith Matilda Catherman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Ie m eny Injury or other traum <u>once.</u> 4826 Bayfair Street Pasadena, TX 77505 Lawrence A. Smith Jr. Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem. Grdns 11/2/2006 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Funer Service Ocensie M00176 106 East Church Street Frederick, MD 21701 23a. Part1 enter the disease, or complications that caused the death. s ck, or heart failure. List only one cause on each line. mirriediate Cause (Final **Physician** disease or condition resulting in death) 🌂/Medical Due to (or as a consequence of): xaminer Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying gause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 ☐ Yes 2 🗸 📆 1 🗇 or Attending Physicien: Medical Certification; To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No death. efter death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral ( Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Baltimore, Maryland 21215-0036

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	nysician /Medical Examiner		· · · shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	aDue to (or as	ine.	e 7	-	-	-		l In		ction	Approximate Interval Between Onset and Death
),¿	physicien and the burial-transit	Examiner	Sequentially list conditions, as a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as										
×	ath certifi attending   for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \)	d d. If yes, outcome 1 □ Live birth 4 □ Pregnant a	2 Feta	death	3 □Ectopic p 5 □ Other (s <sub>i</sub>		1	-	,	230	d. Date of deli	ivery Day Year
O.	by the de	hys	9 Unknown	9∐ Unknown										
rds, F	w requires that the been signed by th should be detache		Part II. Other significant conditions con	ntributing to death b	out not res	ulting in the	e underlying o	ause giv	en in Part I.		23e. Did t	_		the cause of death?
l Rec	The law ete hes b page 2 sl	Completed									24a. Was autop perfo 1 Yes		prior to death?	topsy findings available completion of cause of 2 \square No
/Ita	ysician: Th us certificete director, pag	Be (	25. Was case referred to medical examiner?			/		1.00			(Check only o			
100	Attending Physicien: In death. Sector: After this certific by the funeral director,	on; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpati 1 ☐ Inpati 28a. Date of Inju (Month, Da	ury	ER/Outpar 28b. Time Injur		DA Oth 28c. Injur Wor			me 5 Resident			cify)
0 0	uttandir death. ctor: Al y the fu	catic	2 Accident investigation				М	1 🗆	Yes 2 □ i					
Division of	2 = = -	Certification;	3 Suicide 6 Could not be determined	28e. Place of In building, e	jury - At ho tc. <i>(Specif</i> )	ome, farm,	street, factor	y, office			28f. Location (3 City or Tox		Number or Ru	ral Route Number,
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exami	sician: To the best ner: On the basis of and manner st	of examina	wledge, de tion and/or	eath occurred investigation	at the tir i, in my c	ne, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s) an date and pl	d manner as ace, and due	stated. to the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier	/					e number				signed (Mont	
	5		1 sune	me	>		I	00	542	-85		11 -	03-	2006
			30. Name and address of person who co	•				V115	HI	CF	RSTOI	NINI	MD	21742
	Sta	te	31. Date filed (Month, Day, Year)	32 Regist			8 .0		1111	.00		- 010		(11)
1	Regist		NOV 1 3 200	10 free sin	See Se	T. A	100456							

State Registrar 29b. Signature and title of ce

SUNIL K. 31. Date filed (Month, Day, Year)

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

32. egistrar's Signature

GUPTA,

2006

625 KENT AVE., SUITE 101, CUMBERLAND, MD

29c. License number

00033280

29d. Date signed (Month, Day, Year)

21502

November

6

2006

	• • •	•	1 - For State Registrar	ate of Maryland /		artment <i>tificate</i>			ınd M		giene Reg. No.	006	358	74
ı	Physici /Medi		1. Decedent's Name (First, Middle, Last) MARY REBECCA SLICK							2. Date of Dea Month Novembe	Day	2006	3. Time of 6:101	
	Examir		4a. Facility Name (If not institution, give street Ravenwood Lutheran			4b. City, T Hag			f Death			ounty of Death	1	
	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In yrs. last i	birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	8. Date of Birtl (Month, Day Dec. 21,	(, Year)	Cou	nplace (State cuntry) ryland	or Foreign
	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Itams 23a or 28a-f show evant, the Medical Examiner must be notified at	Director	10a. State 10b. County  Md. Washing  10e. Street and Number	10c. City, To		hsbur					10g. Citizer	n of What Cou		ity Limits 2 🗌 No
	ath wil	ralD	26 N. Main St. P.O	. Box 116				21783	3			U.S	. A	
920	urs after dea al', or Itams Examiner m	by Funeral	1 Never Married 2 Married 1	as Decedent Ever in U.S. med Forces? Yes 2 X No Yes, Give ear or Dates:	1	Vas Decede Yes, specif		panic Orig , Mexican, Specity:	jin? (Spe , Puerto F	cify Yes or No- Rican, etc.)		Race - Amer Black, White pecify:		<b>a</b>
Maryland 21215-0036	within 72 ho ene. than "natur he Medical I	Completed		pleted) 16 ollege (1-4or 5+)	(Give I life. D	ent's Usual kind of work OO NOT use	done du retired)	iring most	of workin	g		of Business/Ir		1200
land 2		To Be Co	6 17. Father's Name (First, Middle, Last) John R. Wiles			Tax C		18. Mother		(First, Middle, R. Barl	Maiden Su		mithsbu	irg
Mary	and and ls m	-	19a. Informant's Name/Relationship (Type, P.C. Raymond Slick (So.							Route Number				
Baltimore,	Pages 1 and 3 lent of Health nt: If itsm 27 ry or other tr.		20a. Method of Disposition  1 \( \Sigma \) Burial 2 \( \Cremation \) 3 \( \Gamma \) Remove 4 \( \Donation \) 5 \( \Other \) (Specify)	20b. Place	of Dispos lery, crem	sition (Name natory or oth g Ceme	of er place,	)   1		9,	20c. Locat	ion - City or T	own, Štate	
Balti	permit. Pages 'Department of H Important: If its any injury or of		21. Signature of Funeral Service Licensee	wis Mo1414		Name and			,		525 B:	hsbury radbury	v Ave.	3
State Sec	Pnysician /Medical Examiner			Due to (or as a consequence	o not ente		of dying,	such as c	ardiac or	respiratory arr			Approximate Interval Bett Onset and I	e ween
A '0928	death certificate be executed e attending physician and id for use as the burial-transit	dical Examiner	Cause (Disease or injury that initiated events c.	Due to (or as a consequence										
P.O. Box 6	that the death certifice ed by the attending ph detached for use as ti	Physiclan/Me	in the past 12 months?	yes, outcome of pregnancy  Live birth 2   Fetal deat   Pregnant at time of death   Unknown		Ectopic preg Other (spec					23d.	. Date of delive Month	,	'ear
	sign d be	by	Part II. Other significant conditions contribut		in the un	derlying cau	se given	in Part I.		23e. Did tot			he cause of de	
Vital Records,	The ate h page	Completed	- obesity							24a. Was a autops perform	y V	4b. Were auto prior to co death? 1  Yes	opsy findings a impletion of ca	ivailable iuse of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ş (-						Check only on	e)			
ō	ling Phys n. After this funeral di	atlon: To	1 162 55 140	1 Inpatient 2 ER/C	Outpatient Time of Injury		Other: Injury a Work? 1  Ye	4 Venurs	28	e 5 🗋 Reside 8d. Describe ho			(y)	
Division	or affe in	Certification:	3 Suicide 6 Could not be determined 286	Place of Injury - At home, to building, etc. (Specify)	farm, stre	et, factory, o	ffice		28	8f. Location (St. City or Town	reet and Ni , State)	umber or Rura	al Route Numb	) <del>0</del> 7,
	ha Hospital in 24 hours a he Funaral I pletely filled	edical	Check only 2 Medical Examiner: O	To the best of my knowledgen the basis of examination and manner stated.	ge, death ind/or inve	occurred at estigation, in	the time, my opir	, date and nion, death	place, an	d due to the ca d at the time, da	use(s) and ate and pla	l manner as si ce, and due to	tated. the cause(s)	
	To tha within 2 To the complet	Σ	29b. Signature and title of certifier			29c. l	icense r	number				gned (Month,		
•			// week				1)4	32	10		11-	6-0	6	
			30. Name and address of person who complet	22611 Jeft	(Type, P しいらい	rint) BL	VD	SMI	NIG	uny, 1	CN	2178	3	
:	Sta Registr		31, Date filed (Month, Day, Year)  NOV 1 3 2006	32. Reĝistrar's Signature		beeks	?						ī.	

			1 - For State Registrar	State of I	Maryland		artment of F rtificate of		nd Menta	al Hygier	2001	6 3	5875
H	Physicia	on	1. Decedent's Name (First, Middle, Las	t)						e of Death	Day Ye	gar 3. Ti	ime of Death
	/Medic		Beatrice J, St				4 0 7			1/5/20			:05 A M
	Examin	ier	4a. Facility Name (If not institution, give				4b. City, Town, o		Jeath		4c. County of I		
S. 3.	Cumoral		Homewood at Crumla  5. Social Security Number 6. Se		Age (In yrs. I	ast birthday)	If Under 1 Year		Hrs. 8. Dat	e of Birth	9	erick Binthplace (S	State or Foreign
	Funeral Director		220-09-7266	□M 21€7F	88	Yrs.	Months Days	Hours	Min. (Mc 5 /	29/191	8	Country) MD	
P	> -		Usual Residence of Decedent  10a, State 10b, County		10c City	, Town or Lo	cation					10d los	side City Limits
faryla	shov a a	ū		1.	Too. City	Frede							Yes 2 XNo
the N	288-1	Director	MD Frederi	.cĸ		Frede	10f. Zip Code			10g. (	Citizen of Wha	it Country?	
death with the Maryland	35 or		7401 Willow Road				2170	) 2			USA		
	tal Hygiene. d other then "naturel", or liems 23s. or 28e-1 show event, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decede			Was Decedent of H	dispanic Origin	n? (Specify Ye	etc.)		American Indi White, etc.	lian,
VIZID-0030 within 72 hours after	or the		1 Never Married 2 Married	1 ☐ Yes 2	🔀 No	-	1 ☐ Yes 2K No	Specify:	derio rriozri,	510.7	Specify:		
OUUSO hours af	al Ex	ed by	3 ₩ Widowed 4 Divorced	Year or Date	s:	16a Dass	death Havel Occur			105		White	
in 72	n "naf	ompleted	15. Decedent's Ed (Specify only highest gra	de completed)		(Give	dent's Usual Occup kind of work done DO NOT use retired	du <i>ring</i> most of d)	f working	160.	Kind of Busin	ess/industry	
with A	r than	E o	Elementary/Secondary (0-12)	College (1-4)	or 5+)		Teacher			E	ducatio	on	
	othe vent,	Be C	17. Father's Name (First, Middle, Last)		,			18. Mother's	Name (First,	Middle, Maid	en Sumame)		
aryland should be file	ind Mental Hygiene. s marked other than " umatic event, the Mac	10	C. Thomas Summe	ers				Helen	Sande	rs			
N	(0 <u></u> 0		19a. Informant's Name/Relationship (7				ng Address (Street					te, Zip Code)	)
an	item 27 other tr		Susan Jenny Boyer 20a. Method of Disposition	Daught		The second second	Corral I	Lane Fr	ederic Date		21/03 Location - City	or Town St	ata
MCr Pages	int of h		1 ⊠ Burial 2 ☐ Cremation 3 ☐		ite Cé	emetery, crei	natory or other pla						
Baltimor permit. Pages	Department of H Importent: If itel any injury or oth once.		<ul> <li>4 □ Donation 5 □ Other (Specify</li> <li>21. Signature of Funeral Service tricen</li> </ul>		Mot		ivet Cem. . Name and Addre		/7/200		ederick		
per per	any ence		) of (	Dhan	M00176		06 East (		,				
/1	ysician Medical kaminer	niner	23a. Rarti-Enter the disease, or comy shock, or heart failure. List only disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a	as a consequal as a consequ	uence of):	1	io Jaçı	,		se		ral Between t and Death
x ob/ou, ertificate be exeq	ding physician at the burial-transit	Medical Examin	resulting in death) Last	d	as a consequ								
ecords, P.O. BOX of law requires that the death certifi	been signed by the attending l should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes S☐No 9 ☐ Unknown	1 Live birth	n 2 ☐ Fetal t at time of de	death 3	Ectopic pregnancy Other (specify)	<i>y</i>			23d. Date of Month	f deliv <i>e</i> ry Day	Ƴ <i>e</i> ar
uires that	signed b	by	Part II. Other significant conditions of	ontributing to deat	h but not resu	ulting in the u	nderlying cause giv	ven in Part I.	23	e. Did tobacc	o use contribu		se of death?
<b>HECOLO</b> he law require	s bee	ompleted	ASTED	1101.95		, , ,			24	a. Was an	24b. Wer	e autopsy fin	dings available
r e	age 2	E		,,,,					_	autopsy performed? Yes 2	deat	r to completio th? Yes 2□ N	
	s certificate has b lirector, page 2 s	Be C	25. Was case referred to medical					26. Place of	Death (Chec			703 2011	-
OT VITA Physicien:	nis ce I direc	To E	examiner? 1 Tes	Hospital: 1   Inp	atient 2 □ l	ER/Outpatier	t 3□ DOA Oth	Nursi	ing Home 5	☐ Residence	6 Other (	Specify)	
	Jeath. tor; After this certific the funeral director.		27. Manner of Death Natural 5 Pending 2 Accident investigation		njury Day Year)	28b. Time of Injury	Wor			escribe how in	jury occurred		
DIVIS tel or Atte	rithin 24 hours after death.  o the Funerel Director; After ompletely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	280. Place of	Injury - At ho , etc. (Specify	me, farm, str	eet, factory, office		28f. Loc Cit	cation (Street y or Town, Sta	and Number o	r Rural Route	e Number,
he Hospi	within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the be liner: On the basi and manne	of examinat	wledge, deatl tion and/or in	n occurred at the tire vestigation, in my o	me, date and popinion, death	olace, and due occurred at th	to the cause e time, date a	(s) and manne ind place, and	r as stated. due to the ca	ause(s)
Tot	within 2 To the compfet	Σ	29b. Signature and title of certifier		1-		29c. Licens	e number		29d. [	Date signed (N	fonth, Day, Yo	'ear)
	,		I No	unl	1-	M	D 1	6428			11/4	105	
4	0		30. Name and address of person who							,	04701		
			Dr. Casper E. Cli	_ 32 Rec	.D. 30 istrar's Signal		Ninth S	treet E	rederi	ck, MD	21701		
100	Sta	ate	NOV 1 3 20	Jb Z	crew S	1.	The state of the s						

TOD80305

Known to physician as Beatie Stup DOD:

		1 - For MFND#20 pper FH10/ State MFND#17, 18 per	INF.TO\31\(	f Marylar ,McCo ,6,BW,M	nd / Depa bab <i>Cel</i>	artment rtificate	of H	ealth a Death	and M		Reg. No.		06	358	
Physici	an	1. Decedent's Name (First, Middle, La: Marie Michelle	st) Tebeck	_					l	2. Date of De Month	Day		Year	3. Time of	Death a M
/Media	al					4b Ciby T		Location	of Dooth	Octobe		County of		5:30	
Examir	er	4a. Facility Name (If not institution, given Shady Grove Adve			1	4b. City, T		kvill			40.		tgom		
Funeral		Social Security Number 6. S			. last birthday)	If Under 1	Year	If Under	24 Hrs.	8. Date of Bir	th		9. Birth	place (State o	or Foreign
Funeral Director			□M 2K□F	48		Months	Days	Hours	Min.	Jan. 8	y 195	8	Hai	t1	
ס		Usual Residence of Decedent		· · · · · · · · · · · · · · · · · · ·											
rylan Ihow		10a. State 10b. County		10c. C	ity, Town or Lo	cation								10d. Inside Ci	•
9 Ma	cto	Maryland Montgon	nery		Rocky	ville								1 🗆 Yes	5 <b>X</b> □ N0
ING Z1Z13-UU36 be filed within 72 hours after death with the Maryland hal Hygiene. Id other than "natural", or items 23a or 28a-f ahow event, the Madical Examinar must be notilised at	Directo	10e. Street and Number				10f. Zip (	Code				10g. Citi	zen of W	/hat Cou	intry?	
ath w		13303 Arctic Ave				208						USA			
er de item	Funeral	11. Marital Status	Armed Fo		J.S. 13.	Was Decede If Yes, specif	ent of Hi fy Cuba	spanic Ori n, Mexicar	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)	)-		e - Amen k, White	ican Indian, , etc.	
rs aft	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Giv Year or D	re		1 ☐ Yes 2	⊠ No	Specify:				Specify:	:	Black	
Z15-UU36 Ithin 72 hours af ie. nan "natural", or Medical Exam	ed	15. Decedent's E	1	u.103.	16a. Dece	dent's Usual	Occupa	ation			16b. Ki	nd of Bu	siness/lr	ndustry	
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VIV.	E	Elementary/Secondary (0-12)	College (1 2	-40r 5+)		Nurs	е					Med	dica	1	
filed Hygi other	BeC	17. Father's Name (First, Middle, Last,	ico							(First, Middle		Sumam	θ)		
should be and Mental marked o	ToB	Hubert Blaine Bla Herbert Blaine	ııse				-	Pnan 1	e <del>GΩ</del>	rquette	}				
ire, Maryla s 1 and 2 should of Health and Men item 27 is marke other traumatic.		19a. Informant's Name/Relationship (	Type, Print)		19b. Mailie	ng Address (	(Street a	and Numbe	er or Rura	I Route Numb	er, City o	r Town,	State, Zi	p Code)	
and 2 and 2 salth a n 27 ls		Lazarus N. Tebec	k/ Hust	and	13303	3 Arct	ic /	Avenu	e, R	ockvil	le, M	1D 20	0853		
or He roth		20a. Method of Disposition 1 D Burial 2 ☐ Cremation 3 ☐	Damount from		Place of Dispo	sition (Name	e of her place	e) .		obar 11	20c. Lo	cation -	City or T	own, State	
Haltimore, Maryland  Semit. Pages 1 and 2 should be file Dept. The pages 1 and 2 should be file Mportant: If item 27 is marked othe mp njury or other traumatic event, 2056.		4 □Donation 5 □ Other (Specif			te of Hea	ven Cen	neter	У		iber <del>3</del> 06	ilve	er S	rin	g, Mar	vland
Baltimo permit. Pag Dep: riment Important: Il any njury o		21. Signature of Funeral Service Licer	nsee		F21	Name and	Addres	s et Facilit	ins	Funera					
<b>20</b> +√82,		Acons	5 Qa	Ly						, W, S:				, MD 2	0901
Physician		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on e	ach line.	ath. Do not ent			g, such as	cardiac o	or respiratory a	rrest,			Approximat Interval Bet Onset and I	ween
/Medical Examiner		resulting in death)		or as a conse		- Janpan									
Examiner		Sequentially list conditions,		Failu										Days	
Si 9d	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		or as a conse	_										
end end I-tran	хап	that initiated events resulting in death) Last	C.	re Acid orasaconse									-	Hours	
8 / 60, rate be executed hysicien end the burial-transit			240.00	(or <b>us</b> u <b>s</b> or ros	4001100 01).										
physicate	g		_ d												
. BOX b8 / bU, death certificate be executed e attending physicien end id for use as the buriat-transit	Physician/Medical	IF FEMALE:	23c. If yes, out	come of pregn	nancy							23d Dat	o al dalis	107/	
Bath of attention for u	lan	23b. Was decedent pregnant in the past 12 months?	1 Live b	inth 2 ☐ Fet ant at time of	tel death 3	Ectopic pre					1	23d. Date Mor			Year
	ysi	1 ☐ Yes 2 125 No 9 ☐ Unknown	9□ Unkno			2 <b>-</b> (110)									
S, P.O.		Part II. Other significant conditions	ontributing to de	eath but not re	sulting in the u	nderlying ca	use give	en in Part I.		23e. Did	tobacco u	se contr	ibute to	the cause of c	leath?
VITAI MECOTAS, sician: The law requires t certificate has been signe rector, page 2 should be o	d by									1 🗆	Yes 2	No	3 🗆 Pro	bably 4 🗆	Jnknown
COLD  w require been si	Completed									24a. Was	an	24h V	Vere aut	opsy findings	available
The lay ate has page 2	Ę									auto		D d	rior to co leath?	ompletion of c	ause of
VITAL Priclan: The certificate	e Co	25. Was case referred to medical						00.01	-4 D41	1 Yes		1	Yes	2□ No	
Of VITA Physician: this certific ral director.	80	examiner?  1 Yes 2 No	Hospital:	npatient 2	☐ ER/Outpatier	nt 3 DO	Othe	200		me 5□Resi		6 🗆 Othu	ne (Cana	.6.1	
g Physicarthis	. To	27. Manner of Death		of Injury	28b. Time o		Bc. Injury	at at		28d. Describe				(Y)	
The standard of the standard o	ig ig	1 X Natural 5 ☐ Pending 2 ☐ Accident investigatio		th, Day Year)	Injury	м	Work 1 □ \	<br Yes 2 ☐	No						
DIVISION OF  for Attending Physical death.  Director: After this lin by the funeral di	ertification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	289. Place		home, larm, str	reet, lactory,	office			281. Location ( City or To			er or Ru	al Route Num	ber.
s after so in Director by the big birds of the birds of t	Cert	7 E Tronnoido	Dulla	ng, etc. (Spec	···y/					Ony 01 10	····· Jiale	,			
Hospital	) al	23t Certifier 1X Certifying Pt	yelcian. To the	best of my kn	nowladge, dast	hi denumed a	s the tim	na, data ah	id place.	and due to the	causa(s)	and ira	Ther are	stated	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	edical	(Check only 2 Medical Example)	and man	asis of examin ner stated.	ation and/or in	vestigation,	in my op	union, dea	un occurr	ed at the time,	gate and	ріасе, а	and due	to the cause(s	)
To the To the Comp	Σ	29b. Signature and title of certifier				29c.	License	number				-	•	Day, Year)	
5		Drivil ()	~ X L		MA	D	06	544	44		00	103	IR	26,2	006
		30. Name and address of person who					187-2		775					de la	
		Arijit Dasgupta			dical	Center	Dr	ive,	Rock	ville,	MD 2	20850	0		W.55174
Sta	ate	31. Date filed (Month, Day, Year)		legistrar's Sign	nature	aske)									

06-07729 Please Type or Print in Black Indelible Ink Ferdinand Tabod State of Maryland / Department of Health and Mental Hygiene 2006 35877 Certificate of Death Reg. No. Registra 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day October 14, 2006 **Medical Examiner** FERDINAND TABOD 2207 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death c. County of Death **Doctors Hospital** Lanham Prince George's 5. Social Security Number 6. Sex Age (In yrs, last birthday) **Funeral** If Under 1 Year If Under 24Hrs. 8 Date of Birth (MM/DD/YYYY) 9 Birthplace (State or oreign CAMEROON Months Director Days Hours Min 389-88-5951 1 XM 2 Yrs MARCH 23, 1958 Usual Residence of Decedent 10a State any 10b. County 10c. City, Town or Location 10d Inside City Limits 1 X Yes 2 No 28a-f show portant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ury or other traumatic event, the <u>Medical Examiner must be notified at once.</u> Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. MD PRINCE GEORGE NEW CARROLTON Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 5328 85th AVENUE #D9 20784 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White etc. Yes 2 X No 4 X Divorced 3 Widowed If Yes, Give Year 1 Yes 2 X No specify: BLACK Specify \$ or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4yrs NURSE PRIVATE 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) ESTHER FORTU JOHN TABOD æ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MARGARET TABOD/SISTER 5328 85th AVENUE #D9 NEW CARROLTON, MD 20784 permit Pages 1 and 2.
Department of Health a 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State ML. 18 MBENGWI 11-04-2006 CAMEROON, WA Important: Donation 5 Other Specify JB JENKINS FUNERAL HOME 21. Signature of Funeral Service License 22. Name and Address of Facility 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part I. Enter the of sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical a. Pulmonary Thromboembolism Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b. Deep leg vein thrombosis Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical attending physician or use as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate by IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ acquired immune deficiency syndrome 1 Yes 2 No 3 Probably 4 Unknown Completed ncate has been s., page 2 should b 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed? Yes 2 V No 1 Yes funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Be Other<sub>4</sub> Inpatient 2 FR/Outpatient 3 00A Nursing Home 5 Residence 6 Other 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Pending 1 Yes 2 No after death. the To the Funeral Director: Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 15, 2006 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

Registrar DHMH 17 Rev 1/2001

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Registrar's Signatu

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		Decedent's Name (First, Middle, La	ıst)					2. Date of Death	<del></del>	3. Time of Death
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arylan ehow		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
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r dea	le l	11. Marital Status	12. Was Decede	ent Ever in U.	.S. 13.	Was Decedent of H	Hispanic Origin? (	Specify Yes or No- irto Rican, etc.)	14. Race - Ame Black, Whit	
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itied within 72 hours effer death with the Maryland Hygiene. Hygiene. In Madical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	pation during most of w	orking	16b. Kind of Business	/Industry
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s 1 end f Heelth item 27 other tr		20a. Method of Disposition	ret (MII						20c. Location - City or	
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		23h. PMHI. Enter the disease, or con							urg, Maryl	Approximate
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Physician / /Medical		disease or condition resulting in death)	a #4	POI	BNSI	DN				
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ospit hour unere ly fille		29a. Certifier 1 Certifying P	hysician: To the b	est of my kno	wledge, deat	h occurred at the ti	me, date and place	ce, and due to the ca	use(s) and manner as	s stated.
To the Hospital or Attending Physician: The law within 24 hours elter death.  To the Funerei Director: After this certificate hes completely filled in by the funeral director, page 2	edicai	(Check only 2   Medical Exa	miner: On the bas and manne	r stated.	uon and/or in	vestigation, in my	opinion, death occ	curred at the time, da	ite and place, and due	e to the cause(s)
Withi To t	Σ	29b. Signature and title of certifier	0			29c. Licens	se number	29	d. Date signed (Mont	h, Day, Year)
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5		30. Name and address of person was	completed cause	of death (Item	n 23a) (Type,	Print)	11 :		1-1-	
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Section   Personal Properties   Personal P	ပ္ပ	s bee	olet							24a. V	Vas an	24b. Wer	e autops	y findings available
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1 Natural 2 Accident 3 Suicide 4 Homicide 4 Homicide 5 Pending investigation 6 Could not be determined building, etc. (Specify)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier investigation and manner stated.  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  1475 Taney Avenue #204  25d. Describe 100 minuty occurred at Month?  1 Natural 2 Accident 3 Suicide 4 Homicide 6 Could not be determined building, etc. (Specify)  1 Natural 2 Accident 3 Suicide 4 Homicide 6 Could not be determined building, etc. (Specify)  28e. Place of Injury At home, farm, street, factory, office City or Town, State)  29a. Certifier (Check only one)  29b. Signature and title of certifier investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29c. License number 29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)		hysic his ce I dire		1 ☐ Yes 2 🔀 No	1 [] Inpatier		VOutpatien	t 3 DOA	Other: 4 🖾 Nursin	g Home 5 🗆 F	Residence	6 Other (	Specify)	
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Tames S. Grussom 1475 Taney Avenue #204 Frederick, Maryland 217		Hospit. 24 hours Funera		(Check only 2 Medical Ex	aminer: On the basis of	examination	edge, death n and/or inv	occurred at the	e time, date and play opinion, death o	ace, and due to courred at the ti	the cause me, date a	(s) and manne and place, and	or as state due to th	ed. ne cause(s)
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James S. Grussom 1475 Taney Avenue #204 Frederick, Maryland 217		OI		30. Name and address of person wh	o completed cause of de	ath (Item 20	3a) (Type.							
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100	Examin Funeral Director	er		Sex 7. Age (In yrs.	AL	y, Town, or Location of Deat  ELKTO  ler 1 Year If Under 24 Hrs s Days Hours Min.	N	dc. County of Death  9. Birthplace (State or Foreign Country)	ţ
	70	ior	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Location	ill=	73/12	10d. Inside City Limits 1 ☐ Yes 2 🖪 No	_
	3a or 28a	al Director	10e. Street and Number	IAGE STR	LEET 10f.	27938	10g. C	Citizen of What Country?	
980	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Itam 27 is marked other than "natural", or Reme 23e or 28e-f ehow other traumatic event, the Medical Examinat must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1	.S. 13. Was Dec If Yes, s	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puen 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK	
21215-0036	filed within 72 ho Hygiene. other than "natur ent, me Modical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	life. DO NOT	work done during most of wo	rking 16b.	Nind of Business/Industry DomeSTIC	
Maryland	should be filed and Mental Hygi ie markad other aumatic event, II	To Be C	17. Father's Name (First, Middle, Last	LEARY		SAL	ne (First, Middle, Maide PAH DC/	11A BAINES	
	s 1 and 2 sh if Health and Itam 27 ie m other traum		19a. Informant's Name/Rela onship  +CDFU  20a. Method of Disposition	JALTUN 20b. F	POB 5	ss (Street and Number of Richards)	Ville, 1	V C 27438  Location - City or Town, State	
Baltimore,	permit. Pages Department of Important: If It any injury or o		1 durial 2 Cremation 3 [ 4 Donation 5 Other (Speci	_Removal from State	Demetery, crematory of LDY F	AMIN COM and Addr s of Facility	10/28/06	GATES, NO.	2/3
	Pnysician /Medical Examiner		23a. Part1. Enter the discrete of conshock, or fear to ure. List only Immediate Cruse (Pinal disease or condition resulting in eath)	pplications that caused the deat y one cause on each line.  a	ute My juence 1):	ode of dying, such as cardia COCAPOINT (	c or respiratory arrest.	Approximate Interval Between Onset and Death	10
8760,	cate be executed ohysician and the burial-transit	dical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a consequence)  d.					
P.O. Box 68	Attending Physician: The law requires that the death certificate be executed rideath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregn: 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c	ıl death 3 □Ectopic			23d. Date of delivery Month Day Year	
	quires that n signed by ald be deta	ed by Ph	Part II. Other significant conditions	contributing to death but not res	sulting in the underlying		23e. Did tobacco	o use contribute to the cause of death?	
Il Records,	yeician: The law require is certificate has been sig director, page 2 should b	Completed	hyper	lipidania	,		24a. Was an autopsy performed? 1 ☐ Yes 2 ☑		
Vital	eician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	TEDIO	Othor	ath (Check only one)		-
of	ttending Phyedeath. ctor: After this y the funeral di	ation: To	1 Yes 2 No  27. Manger of Death 1 Natural 5 Pending 2 Accident investigator	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	DOA   Curer 4   Nursing H	fome 5 ☐ Residence 28d. Describe how in		-
Division	To the Hospital or Attending Phaythin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	3 Suicide 6 Could not determined	building, etc. (Special	/y) 		City or Town, Sta	/	
	Mosp 24 hou Fune etely fi	Medical	29a. Certifier  (Check only one)  1 Certifying P  2 Medical Exa	Physician: To the best of my kno iminer: On the basis of examina and manner stated.	owledge, death occurr ation and/or investigati	ed at the time, date and place on, in my opinion, death occi	e, and due to the cause( urred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)	
	To the vertical Complete Compl	Me	29b. Signature and title of certifier	the way		29c. License number 56811	()°c	Date signed (Month, Day, Year)  10 BER 21,2006	
CA	C(3)		30. Name and address of person who	Sumpleted cause of death (Item	m 23a) (Type, Print) 7 ANIAN	106 Bou	151 Kh	KTON MD 21921	,
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  OCT 2 6 2006	32. Registrar's Signi	does!				1000

State of Maryland / Department of Health and Mental Hygiene-35881 Reg. No. Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2006 Revis Williams October 3:45 PM Mae /Medical 4b. City. Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street end number) Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 5-15-1915 7. Age (In yrs. lest birthday) 5. Social Security Number 9. Birthplece (State or Foreign **Funeral** Days 1□ M 2₩ F Ashville, NC Yrs 242-03-4946 91 Director Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Merylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits nast be notified at 1 Yes 2 No Director MD Prince George's Brentwood 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 3413 Tilden Street 20722 United States Herns 23a Be Completed by Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Merried δ 1 ☐ Yes 2X No Specify: White Baltimore, Maryland 21215-0020 Specify: 3X Widowed 4 ☐ Divorced Year or Detes 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Deportment of Health end Mentel important: if item 27 is marked or any injury or other traumatic eva Milton Revis Daisey Gallienne 2 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Edward Gary Williams (son) 5807 Quintana Street Riverdale, MD 20737 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 10/28/2006 Brentwood, MD Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service License 3401 Bladensburg Road Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Examine the bunel-trensit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of) 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown ģ 2 24b. Were eutopsy findings aveilable prior to completion of cause of death? Be Completed 24a. Wes an autopsy performed? 1 Yes 2 No 2 TNO 1 ☐ Yes 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Hospital: Other: 1 Inpatient 2 No Certification: To 1 ☐ Yes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter deeth.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Fo the Hospital 29a. Certifie 1 Certifying Phyeicien: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of completed cause of death'(Item 23a) (Type, Print State Registrar

			For State Registrar	Sta	ate of	Maryland	•	artmen rtificat			and M		giene	' U U	6	35882
	Physici /Medic		1. Decedent's Name (First, Middle	, Last)	ĺ	Nest	-	ار.				2. Date of De.	Day 2		өөг О ( <sub>6</sub>	3. Time of Death  3. 50 f M
	Examin		4a. Fecility Name (If not institution Howard County						Town, or Lumb.	Location o	f Death		4c.	County of Howa:	_	·
	Funeral Director		5. Social Security Number 211 30 8935	6. Sex <b>X</b> XM 2		. Age (In yrs. la:	st birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bird May 20	th y, Y230	10 N	. Birthp Coun	lace (State or Foreign Tersey
	nyland show		Usual Residence of Decedent  10a. State 10b. County				Town or Lo								1	Od. Inside City Limits
	the Ma	Funeral Director	MD Howa:	rd	-	Cla	arksv:	ille	Code				10g. Citi	zen of Wh	at Coun	1 ☐ Yes 2 <b>₹</b> ∑¶No try?
	ath with	rai Di	11752 Clarksv						2102					USA		
980	urs after de al', or Iteme Evaminer m	þ	11. Marital Status  1 □ Never Married 2 → Marria 3 □ Widowed 4 □ Divorced	ed 1 [	as Deced med Forc	<b>™</b> No		Was Deced If Yes, spec 1 ☐ Yes		ispanic Origin, Mexican Specify:	gin? (Sp , Puerto	ecify Yes or No Rican, etc.)	<b> -</b>	14. Race - Black, Specify:	White,	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene Importent: If Item 27 is marked other than "natural", or Items 23a or 28s-f show warp injury or other treumatic avent, Ita Medical Examinar must be notified at ADDS.	Completed	15. Deceden (Specify only highe: Elementary/Secondary (0-12)	t grade com		4or 5+)		dent's Usua kind of wo DO NOT us Pre	rk done d se retired	turing mosi ')	t of work	ing	Foo			dustry cations
Maryland 2	uld be filed Mental Hyg irked other	To Be C	17. Father's Name (First, Middle, Charles N. We		•							e (First, Middle, n Schoef				
Many	id 2 sho ith and h 27 is ma treuma		19a. Informant's Name/Relations Donna West/wife	nip <i>(Турө, Рі</i> Э	rint)		19b. Maili 1175	ng Address 2 Cla	(Ştreet a rksv	ille	Pk.	Clarks	er, City o SVII.	le, M	ate, Zip	21029
	ges 1 ar t of Heal if Item 3 or other		20a. Method of Disposition 1 □ Burial 2 ②Cremation	3 □Remov	al from St	200	ce of Dispo	natory or o	ne of ther plac	. 1		Date		cation - Ci		
Baltimore,	mit. Pag bartmen bortent: Injury :		4 ☐ Donation 5 ☐ Other (S 21. Signature of Funeral Service			Met:	ro Cr					7/2006 rv H. V				MD lly FH, Inc.
Ä	Depa Impo eny la		Vervil!	Redd	_		4	112 0	ld C	olumb	ia I	k. Ell	Lico			
	Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cau	ise on ead	Seps	is	er the mod	e or ayını	g, such as	cardiac	or respiratory a	rrest,			Interval Between Onset and Death
ı	Examiner		Sequentially list conditions,	b	· ·	ras a conspique										ί
,	ite be executed ysicien and te burial-transit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.		r as a conseque r as a conseque									-	
68760,	cate be physicie the bur	cal		d											U	
P.O. Box 6	The law requires thet the death certificate be executed tile has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	10	Live birt	ome of pregnand th 2 ☐ Fetal on that time of dea vn	leath 3[	Ectopic pr Other (sp						23d. Date o Month		ory Day Year
	puires thet I n signed by lid be deta	þ	Parli. Other significant condition  Acute Rena	ons contabut	ing to dea	th but not result	ing in the u	nderlying c	ause give	en in Part I.		23e. Did t				ne cause of death? ably 4 □Unknown
Records,	The law requirence has been so	Completed	Esophageal	Cai	ncer									prio	r to cou	psy findings available impletion of cause of
Vital	Physicien: The lav this certificete has ral director, page 2	Be	25. Was case referred to medica examiner?	Hospita	al: V		***		Oth	0.00		h (Check only o	one)	-		
ð	fter fter ner	tion: To	1 Yes 2 No  27. Manner of Death  1. Natural 5 Pendir 2 Accident investi	28: g	a. Date of		R/Outpatier 28b. Time o Injury		8c. Injun	4 LINU		ome 5 Resi	**			/)
Division	To the Hospital or Attendity within 24 hours effer death.  To the Funeral Diractor: A completely filled in by the fu	Certification:	3 Suicide 6 Could determ	not be	e. Place o building	of Injury - At hong, etc. (Specify)	ne, farm, st	reet, factory	, office			28f. Location (. City or To	Street an wn, State	d Number )	or Rura	l Route Number,
	Hospit 24 hour Funera stely fills	Medicai (	29a. Certifier Certifyir (Check only one)	Examiner: C	: To the b	est of my know is of examination	ledge, deat on and/or in	h occurred vestigation	at the tim , in my of	ne, date an pinion, dea	d place, th occur	and due to the red at the time,	cause(s)	and mann I place, and	er as si	ated. the cause(s)
	To the Within To the comple	Me	29b. Signature and tille of certifie					290		number			m			Day, Year)
13	, 5		30. Name and address of person	who complet	NO ted cause	of death (Item :	23a) (Type	Print)	123	362	/		ICT	2	4,	2006 4021044
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			For Stata Registrar	State of N	laryland / De	partment of e <i>rtificate o</i>				iene g. <b>n</b> 2 0 0 (	5 35883
		1. A. A. A. A. A. A. A. A. A. A. A. A. A.	1. Decedent's Name (First, Middle, La	st)				2	Date of Death		3. Time of Death
	Physici /Medic	7 1	Virginia W	hipp				0	ctober	28 20	
	Examir		4a. Facility Name (If not institution, give	e street and numbe	r)	4b. City, Town	, or Location of	of Death		4c. County of	Death
			7351 Willow Road				derick	24110			erick
Nº	Funeral		5. Social Security Number 6. \$ 230–20–7083	6ex 7. A I□M 2⊠F	Age (In yrs. last birthda 81 Yrs.	y) If Under 1 Ye. Months Day		Min.	Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		01			J	uly 21	, 1925	Virginia
	yland		10a. State 10b. County		10c. City, Town or	Location					10d. tnside City Limits
	a-fel	ctor	Maryland Frederi	ck		Frederi	ck				1 ☐ Yes 21 No
	or 28	Director	10e. Street and Number			10f. Zip Code	•		10	g. Citizen of Wha	af Country?
	23a		7351 Willow Road	Cottage	12	21	702			United	States
	teme teme	Funeral	11. Maritat Status	12. Was Deceder Armed Forces	5?	<ol> <li>Was Decedent of If Yes, specify C</li> </ol>	of Hispanic Ori uban, Mexican	igin? (Specif n, Puerto Ric	fy Yes or No- can, etc.)		American Indian, White, etc.
36	', or l	by F	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 □Yes 2 dive		1 ☐ Yes 2 🌇 Ñ	lo Specify:			Specify:	White
8	within 72 hours atter death with the Maryland ene. Than "natural", or lieme 23a or 28a-f ehow ha Madical Examinar must be notitied at	edt	15. Decedent's E			cedent's Usual Occ	cupation		11	6b. Kind of Busin	aess/Industry
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/lai	should b ind Mente marked umatic e	2	Arthur Pike, Sr	•			Na	ancy E	sther (	Cole	
Maryland 21215-0036	01 00 07 05		19a. Informant's Name/Relationship (	Type, Print)	19b. Ma	iling Address (Stre	et and Numbe	er or Rural F	Route Number,	City or Town, Sta	ate, Zip Code)
	1 and 2 Health tem 27 i		Fern Godbee / Ni	ece		Teakwood	d Court	-			
Baltimore,	0 0	ľΥ	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from Stat	comotoni c	position (Name of rematory or other p	olace)	Date Novemb		loc. Location - Cit	ty or Town, State
Ë	. Pag tmeni tent: jury		4 □ Donation 5 □ Other (Special	y)	Mt. Oliv	et Cemet	ery	2, 200	06 F		, Maryland
3al	permit. Pag Department Important: I any Injury o		21. Sign fure of Puneral Service Lice	nsee /							omes, P.A.
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	/Medical Examiner		Toolshing in dodain,	3 8	s a consequence of):						
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68	tificate ig phys as the	Physician/Medical									
Вох	death certific e attending p od tor use as i	N/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		B⊟Ectopic pregnar	nov.			23d. Date o	of delivery
. B	0 0 0	SICIE	in the past 12 months? 1 ☐ Yes 2 🖾 No			Other (specify)				Month	Day Year
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of	9 9		1 ☐ Yes 2 ☒ No	1 Inpa		ent 3 DOA	Other: 4 Nu	rsing Home		nce 6 Other (	Specify)
LO C	Phys this ral dii	-T	27 Manner of Death		unu 28h Time	of 29c in	uunc at	290			
	ding Phys h. Atter this funeral dii	-	27. Manner of Death  1 🖾 Natural 5 🗌 Pending	28a. Date of In (Month, D	jury 28b. Time lay Year) Injury	V			d. Describe how	w intury occurred	
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	Hospital or Attending Phys 4 hours after death. Funeral Director: After this ely tilled in by the funeral di	Certification: T	1 \( \) Natural 2 \( \) Accident 3 \( \) Suicide 4 \( \) Homicide  5 \( \) Pending investigation 6 \( \) Could not be determined	28a. Date of In (Month, C	njury - At home, farm, etc. (Specify)  It of my knowledge, de of examination and/or	M 1 street, factory, office ath occurred at the	Yes 2 1	No 28f	Location (Stre	eet and Number of State)	er as stated.
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Division or Vital Records, P.O. Box 68760,	
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	-	For State Registrar	State of M	arylan		artment of H tificate of I	lealth and M <i>Death</i>		giene Reg. No. 🤈	006	25001
tig .	-	Decedent's Name (First, Middle,	Last)					2. Date of Dea		<del>J U (</del>	3. Time of Death
Physicia /Medic		Elvira Marie W:	illiams					October	22,	200	62:40A M
Examin		4a. Facility Name (If not institution,	give street and number)			4b. City, Town, or Location of Death			4c. Cour	ity of Dea	th
	186	Doctors Hospita	a1			Lanham			ł	e Ge	orges
Funeral Director		5. Social Security Number 266-58-7410	6. Sex 7. Ag 1 ☐ M 2 🖾 F	je (In yrs. I 86	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 04/09/	h, <i>Year)</i> L <b>9</b> 20	9. Bir Co Ohi	thplace (State or Foreign ountry) O
D.		Usual Residence of Decedent		10- 00	T						404 1-14- 05-11-5-
anylar show dat	_	10a. State 10b. County		Tuc. City	, Town or Lo	callon					10d. Inside City Limits 1 XYes 2 No
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with t a or 2 be n	늅	10e. Street and Number	w 0 0 *			20720			USA	i winat ot	ounity:
eath is 23	Funeral	6301 Gallery St.	12. Was Decedent	Ever in U	S 13.1		lisnanic Origin? (Sp				erican Indian,
ter d	Fu	1 □ Never Married 2 □ Marrie	Armed Forces?	No		37	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	В	lack, Whit	e, etc.
urs af	by	3X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 No	Specify:		Spe	<i>ify:</i> Wh	ite
2 hou	Completed	15. Decedent	's Education		16a. Dece	dent's Usual Occup	ation	ing	16b. Kind of	Business	/Industry
hin 7 an "n Medi	ble	(Specify only highes Elementary/Secondary (0-12)	College (1-4or	5+)			during most of work d)	.mg			
ygien rt, the	Ö	9			Home	Maker			Own Ho		
tal H d oth	Be	17. Father's Name (First, Middle, I	Last)				18. Mother's Nam	, ,	Maiden Surn	ame)	
ould Men arke	P	Eugene Keyser			T		Sophia V				7.0.11
2 sh n and is m		19a. Informant's Name/Relationsh	, , , ,				and Number or Rui				Zip Code)
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatla and Mential Hygiene. Ininportant: If the XT is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		David Ulevich/ 20a. Method of Disposition	Son	20h. P		sition (Name of	Street B	Date I			Town, State
ages nt of h		1 Durial 2 Dremation			emetery, crej Wood	matory or other plac l I awn	ce)				rown, state
t. Partmer		4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service I		Mem	orial		11/0 ss of Facility $ m Ro$	4/2006			ral Home
permi Depal Impou		21. Signature of Funeral Service I	_icensee				apolis Ro				
		23a. Part1. Enter the disease, or	complications that cause	d the deat							Approximate Interval Between
		shock, or heart failure. List Immediate Cause (Final	only one cause on each I	ine.	_			7.0			Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. CAK Due to (or as			MONAR	7 2	HOCK			
Examiner			Acut	T F		COCAR	DIAL	INFA	RCTI	140	
a the sty	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated overtex	b. Due to (or as	a conseq		W C / IN	1/4	LAI		J. (	
uted	Examine	Cause. Enter Underlying Cause (Disease or injury that initiated events	CORC	NA	RY	ARTER	Y DI	SEAS	E		
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eath certificate be exattending physician for use as the buria	cal		C. SEP	TIC	LEN	NA					
ntifica ng ph as th	Physician/Medica	IF FEMALE:									
ith ce tendii rr use	an/l	23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			☐Ectopic pregnanc	y			Date of de Month	livery Day Year
e dea he at hed fo	sici	in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown	4□Pregnant a 9□Unknown	at time of d	leath 5	Other (specify)				WIOTHIT	buy rour
nat the ded by the etached	Phy	Part II. Other significant condition	ane contributing to death	hut not res	ulting in the u	nderlying cause giv	ren in Part I	23e. Did to	phacco use o	ontribute t	o the cause of death?
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur	d by	URINARY	TRACT		_	TION		10			V
w require been signature should b	ete	DIABETES	MEIL	171	) <			24a, Was	an 24	h Were a	utonsy findings available
has has ge 2	Completed	VIADEIES	INCECC		<u> </u>			autor	rmed?	death?	utopsy findings available completion of cause of
Physician: The lar this certificate has ral director, page 2		25. Was case referred to medical					26. Place of Dea	th (Check only o	2.2 No	1 □ Ye	s 2□No
sicia s certi	o Be	examiner?	The section is a	ient 2□	ER/Outpatie	nt 3 DOA Oth	or.	ome 5 Resid		Other (Sn	aciful
er this	<del>-</del>	27. Manner of Death	28a. Date of Inj	ury	28b. Time o			28d. Describe I		- ' '	iony)
r: Aft	ioi	Natural 5 Pendin 2 Accident investig		ay rear)	Injury		Yes 2 □ No				
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To the Hospital or Attending Is within 24 hours after death. To the Funeral Director: After completely filled in by the funeral		(Check only 2 Medical	g Physician: To the bes Examiner: On the basis	of examina							
the hin 2, the land	Medical	one)  29b. Signature and title of certifie	and manner s	tated.		29c. Licens	se number		29d Date sig	ned (Mon	th, Day, Year)
<b>5</b> ¥ <b>6</b> 8		29b. Signature and the or certain						= 2	106	2/0	-
		30. Name and address of person	who completed course of	death /iter	n 23a) /Tuno		00615	<i></i>	.010	-100	
6		KEVIN K. ELF	AN 8/18	5000	LUCV	ROAN	LAWHA	an, ma	2070	(0	
	ate	31. Date filed (Month, Day, Year)	32. Regis	trar's Signa	ature	1	LAWITA				
Regist	rar	OCT 2	5 2000	Med d	1. B	mode					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2006 **Physician** 19, 6:56 P M Alvin L. Williams Oct. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Holy Cross Hospital Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 XM 2 ☐ F 76 228-34-1811 1, Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Washington 1 X Yes 2 No D.C. N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2916 Nelson Place 20019 United States Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? I 95 I — 1 ∰Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Negro Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Printing Office Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard H. Williams Dorothy L. Green မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard Williams (brother) 1817 Longfellow St., Hyattsville, MD 20782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 10/30/06 4 Donation 5 Other (Specify) Brentwood, MD 22. Name and Address of Facil McGuire Funeral Service 21. Signature of Fugeral Service Licenses 7400 Georgia Ave. N.W., Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiopulmonary Arrest Due to (or as a consequence of) Respiratory failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Sepsis Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 🔲 Yes 2 🗌 No 3 ☐ Probably 4 ⊠Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death vegeration of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23 any injury or other traumatic event, the Medical Examiner must

Baltimore, Maryland 21215-0036

the Medical Examiner must be notified at

with the Maryland

for use as the burial-tran Certification: To filled in by the

or Attending Physician: The law requires that the death certificate be executed and attending physician i signed by the ail peen s after death.

Division or Vital Records, P.O. Box 68760,

To the Hospital within 24 hours a To the Funeral C

Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined

🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number

M.D

D0064100

29d. Date signed (Month, Day, Year) October 20, 2006

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

1500 Forest Glen Road, Silver Spring, MD Smitha Bhikkaji, M.D.

State Registrar

Medical

31. Date filed (Month, Day, Year) OCT 2 7



		1 - State Registrar	State of Marylan		rtificate of L		Reg	2006		
Physici /Medi		Decedent's Name (First, Middle, Last)     EDITH GRUNBERG	WEISZ				2. Date of Death Month OCTOBER 26	Day Year 5, 2006	3. Time of Death 4:00A M	
Examir		4a. Facility Name (If not institution, give s MANOR CARE POTOMAC	treet and number)		4b. City, Town, or POTOMAC		1	4c. County of Deat MONTGOMER		
Funeral Director		5. Social Security Number 6. Sex 579-42-2311	7. Age (In yrs. 82	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y DEC. 21, 19		hplace <i>(State or Foreigi</i> nuntry) TRIA	
land w		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits	
a-fsh	ctor	MARYLAND MONTGOMER	Y	ROCKV	ILLE				tX☐Yes 2☐No	
h with the	ai Dire	10e. Street and Number 7 VALERIAN COURT			10f. Zip Code 20852			D. Citizen of What Co NITED STATES		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumetic svant, the Modical Examinar must be nutilised at 200ce.	by Funeral Director	11. Marital Status  To Never Married  Marned 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	n, Mexican, Puerl	Decify Yes or No-Direction Place - American Indian, Black, White, etc.  Specify: WHITE			
ed within 72 hours af giene. er than "natural", or i, the Medical Exam	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12		(Give life.	dent's Usual Occupa kind of work done o DO NOT use retired INESS OWNER	during most of wor )	rking	16b. Kind of Business/Industry  REAL ESTATE		
i Hygie other sent, II	Be Co	17. Father's Name (First, Middle, Last)					ne (First, Middle, Ma			
Menta Menta arked atic sy	To B	ISAK GRUNBERG					NE SOKALER			
nd 2 should be file lith and Mental Hy 27 ts marked oth r traumatic svent		19a. Informant's Name/Relationship (Ty) BERNARD M. WEISZ - SON	oe, Print)				ural Route Number, C KVILLE, MD 2	,	Zip Code)	
mit. Pages 1 ar partment of Hea portant: if Itsm y injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ AB 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	emetery, crei	osition (Name of matory or other place MEMORIAL G.	1		C. Location - City or		
permit. Departm Importa sny Inju		21. Signature of uneral Service License	e ·				NES RINALDI VE, SILVER S			
Physician /Medical Examiner physicien and bulysicien and physicien and strength and	edicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list or Ultime, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a))).	uence or):	T ARE	FACC	ンショントル	7 E		
death certii e attending ed for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ∐Live birth 2 ∏Feta 4 ∏Pregnant at time of d 9 ☐ Unknown	I death 3[	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year	
requires thet the been signed by th hould be detache	þ	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause give	en in Part I.		cco use contribute lo	the cause of death?	
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Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	ospital: 1   Inpatient 2	ER/Outnatier	nt 3 DOA Othe		ath <i>(Check only one)</i> Iome 5 🗆 Residen	re 6 Mother (Spe	Cuful	
Attending Phy r death. ector: After this by the funeral of	ıtlon: To	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injun World	/ at	28d. Describe how		ony)	
2 # 15 E	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury · At h building, etc. (Specif		reet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number,	
B Hospital 24 hours a Funaral I etely filled	edical C	29a. Certifier (Check only one)  1 Certifying Physical Candidate Examination	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, deat tion and/or in	h occurred at the time vestigation, in my of	ne, date and place pinion, death occu	e, and due to the cau arred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)	
To the To the Complet	Me	29b. Signature and title of certifier	0( 0		29c. License	number	290	I. Date signed (Mont	h, Day, Year)	
20		h	M			0512	50	10-26	-1006.	
		30. Name and address of person who co DR. DADGAR 9715	mpleted cause of death (Item MEDICAL CENTER I	n 23a) (Type. DRIVE,	Print) SUITE 201,	ROCKVILLE	, MD 20852			
St	ate rar	31. Date filed (Month, Day, Year)	32 legistrar's Signa	The A	gale)					

			For State Registrar	State of	of Marylan	•	artment rtificate					giene () (	06	35887
	Dhusisi		1. Decedent's Name (First, Middle	e, Last)							2. Date of Dea Month	th	Year	3. Time of Death
	Physici /Medic		CLEAORN WILSON				<del>,</del>				OCTOBE			10:29A <sup>M</sup>
7	Examin	er	4a. Facility Name (If not institution				4b. City,		Location o	of Death		4c. County		
			SOUTHERN MARYI	AND HOSP	TAL CEN		If Under		NTON If Under:	24 Hrs	8. Date of Birth			EORGES
	Funeral Director		5. Social Security Number 239 32 8960	XX M 2□F	7. Age (III yrs.	81 Yrs.	Months	Days	Hours	Min.	JAN • 14	(Year)	Count	ace (State or Foreign ry) H CAROLINA
	_		Usual Residence of Decedent			01					JAN. 14	, 1923	NORI	II CAROLINA
	ylanc how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10	d. Inside City Limits
	Ba-f.	cto	MD PRINCE	GEORGES	UF	PPER MA	RLBOR	20						XX Yes 2 No
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21215-0036	d within 72 hours after death with the Maryland liene. r than "naturel", or theme 23e or 28e-f show the Medical Evanther must be notified at	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or I	2 ☐ No ive Dates:	į	1 ☐ Yes 🤅	XXNo	Specify:			Specif	v: BLA	CK
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and m	a la b	Be	17. Father's Name (First, Middle,	Last)							(First, Middle,		18)	
ž	d 2 should Ith and Menity 15 is marketer	٢	FRANK WILSON  19a. Informant's Name/Relations	hin (Tyne Print)		19h Maili	ng Address	(Street a		NNIE	(UNKN)  Il Route Numbe		State Zin	Code
Maryland	2 6 7 8		BRENDA L. MARS		AUGHTER		PARK					STVILLE		
<u>6</u>	s 1 and 2 if Health Item 27 I		20a. Method of Disposition	-	20b. F	Place of Dispo	sition (Nan	ne of	1		Date	20c. Location		
ê E	@ ° = 5		122 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State	SURRECT				10/2	8/2006	CLINT	ON. MI	)
Baltimore,	permit. Pag Department Important: eny injury o		21. Signature of Funeral Service	Licensee	, , , , , ,						L HOME (			
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			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the deat each line.	h. Do not en	er the mode	e of dying	g, such as	cardiac o	or respiratory ari	rest,		Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to	(or as a conseq	juence of):	1			1	1 0	7		
		er	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conseq	uence ol):	190	Ca	rdic	re	Infa	LULION		
	nted Insit	min	cause. Enter Underlying Cause (Disease or injury	<	(	, , .								
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o.	at the de by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Preg 9∐Unkr	nant at time of d nown	leath 5L	Other (sp	өсіту)						•
<u>α</u>	that t		Part II. Other significant conditi	ons contributing to	death but not res	sulting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	bacco use con	ribute to the	e cause of death?
Records,	The law requires that the ste has been signed by th bage 2 should be detache	d by									1 🗆 Y	es 2 🗆 No	3 Proba	abiy 4 ∐Unknown
00	s been si	Completed									24a. Was		Were autop	sy findings available
R	The lay	mo									autop perfor	med?	death?	npletion of cause of
Vital		Be	25. Was case referred to medica examiner?						26. Place	of Death	(Check only of			
of V	Physician: this certific ral director,	ို	1 ☐ Yes 2 No		-	ER/Outpatie			4 🗆 190	rsing Ho	me 5 🗋 Resid	ence 6 □Oth	er (Specify,	)
	ding Phi h. After thi funeral	 0	27. Manner of Death 1   Natural 5 □ Pendir	28a. Date (Mor	of Injury oth, Day Year)	28b. Time of Injury		8c. Injury Work			28d. Describe h	ow injury occur	red	
Sio	Attending it death.	cati	2 Accident investi	not be	a of lainer. As la		М		Yes 2 🗌		201 ) session /6	tract and Mirror		Conta Marchael
Division	al or Attend after death I Director: , d in by the f	Certification;	4 Homicide determ	ined 200. Flac	e of Injury - At h ling, etc. (Specil	ome, iarm, st	reet, lactory	, опісе			281. Location (S City or Tow		er or Hurai	Houle Number,
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in E		29a. Certifier 1 Certifying	ng Physician: To th	e heat of my knr	władga, daat	h coniired i	at the tim	a date an	id place	and due to the r	rause(s) and m	Niner as sta	tlad
	ne Ho n 24 h	edical	(Check only 2 Medical one)	Examiner: On the	pasis of examination of the state of the sta	ation and/or in	vestigation,	in my op	oinion, dea	ith occurr	ed at the time, o	late and place,	and due to	the cause(s)
	To the To the Comp	Ž	29b. Signature and title of certifie	21	P				number			29d. Date signe	d (Month, E	lay, Year)
	$\bigcirc$		M. 760	him	au 1	MHO		100	105	29	99	)0	21	Cb
1	(5)		30. Name and address of person			n 23a) (Type,	Print)	C 11	nn	277	99 ROAL	205		MO2073
			31. Date filed (Month, Day, Year)	HIMIA	Pegistrar's Signa	O /	201	20	RKT	111	ICOAL	o CL	INT	01
	Sta Registr		OCT 2 4	2006	Registrar's Signa	5. A	edi							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month ELBERT B. WILEY 3.30 PM 06 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10/17/1910 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F 293-03-5492 Ohio 96 Director Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Director MD Harford 1 ☐ Yes 2√☐ No Darlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4000 Conowingo Road 21034 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (∑Yes 2 □ No If Yes, Give Year or Dates: 1929—31 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Logistics Civil Service nd 2 should be filed value and Mental Hygic 27 is marked other in treumatic event, II. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Deportment of Heath and Mental Important: If Item 27 is marked eny injury or other treumatic evolate. Emory R. Wiley Minnie Garvin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn McLuckie/Daughter 4041-6 Conowingo Road, Darlington, MD 21034 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Sp Burial 2 ☐ Cremation 3 ☐ Removal from State Darlington Cemetery 11/6/2006 Darlington, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dicensee 22. Name and Address of Facility 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, anock, or heart failure. List only one cause on each line. Harkins Funeral Home, Inc., Delta, PA 17314 Approximate Interval Between Onset and Death Immediate Cause (Final Cardio Respiratory **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Cardiomyopany and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine Congestive Heart that initiated events resulting in death) Last Due to (or as a consequence of): Unlay Elbert M8003098 pivision of Vital Records, P.O. Box 68760 Renal Acme Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown MA N/A 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 2 BNo 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 0 1 Yes 2 No 26. Place of Death | Check only one) Be 25. Was case referred to medical Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 27. Manner of Death 28a. Date of Injury (Month. Day Year) 28b. Time of 28c. Injury at Work? H/A 28d. Describe how injury occurred 1 Matural 5 Pending 1 Yes 2 No 2 Accident N/A Director; 6 Could not be 3 ☐ Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funaral Direct completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Physician 0062704 11.1.06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD BelAir Upper Chescapeace Dr Desai MD 500 21044 31. Date filed (Month, Day, Year) 2. Registrar's Signature State NOV 1 3 2006 Registrar

			1 - For State Registrar	State of Maryland	Cer	irtment of H tificate of L	ealth and I Death		gienez () () (	5 35889
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last	•	Warr	enfeitz		2. Date of Dea Month	Day Yea	76 9:56 AM
	Examir Funeral Director	er	4a. Fadlity Name (If not institution, give The Johns Hopk) 5. Social Security Number 199-32-1290 10	ns Hospital	ast birthday) Yrs.	Baltimo			4c. County of De Baltimo	
	ס	tor	Usual Residence of Decedent	10c. City	Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 → No
	n with the	a Director	100. Street and Number  160 Guernsey	Road		10f. Zip Code	7307	1	0g. Citizen of What (	•
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene important: If item 27 is marked other then "natural', or itema 23a or 28a-1 show say figury or other traumatic event. I'm Michigal Exacting rinal be profiled at ODGE.	by Funerai	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	It	Vas Decedent of His Yes, specify Cubar	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - An Black, Wh Specify:	
21215-0036	within 72 hor lene. then "nature if a Medical E	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	life. [	ent's Usual Occupa kind of work done d O NOT use retired) borer	urina most of wor	king	16b. Kind of Busines Manufact	,
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	and 2 shou aith and M 27 le mai		19a. Informant's Name/Relationship (T) John Kenneth Wa	<sub>rpe, Print)</sub> (husband rrenfeltz	d <sub>19b. Mailin</sub> 160	Guernse	nd Number or Ru y Road	ral Route Number Biglery	City or Town, State,	Zip Code) a • 17307
Baltimore,	Pages 1 ament of He ant: If item ury or oth		20a. Method of Disposition 1	Removal from State	metery, crem	ntion (Name of atory or other place nt Ceme	tery 11		20c. Location - City of Arendtsv:	ille, Pa.
Balt	permit. Departi		21. Signature of Funeral Service Licens	Dank	1		adbury	Ave Sm	vis Funer ithsburg	
	Physician /Medical		23a. Part1. Eigher the diseagle, or compi shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the deeth, ne cause on each line.  Peritonit  Due to (or as a consequ	15	r the mode of dying	, such as cardiac	or respiratory arro	est,	Approximate Interval Between Onset and Death
	icate be executed by physicien and burial-transit a	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	iver	Distruss Disease	Syndrom	e		2 days 15 years
	ath certif titending or use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregnan 1 □Live birth 2 □ Fetal of 4 □ Pregnant at time of dec	death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
rds, P.	quires that the de n signed by the a uld be detached f	β	Part II. Other significant conditions con	ntributing to death but not resul	iting in the un	derlying cause giver	n in Part I.	23e. Did tob		to the cause of death?
Vital Records,	ian: The law require rtificate has been si tor, page 2 should b	Completed						24a. Was ar autops perform 1 \( \text{Yes} \) 2	v prior to	utopsy findings available completion of cause of
Vita	uclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital: 🕠				th (Check only one	9/	
Division of	To the Hospital or Attending Physician: within 42 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, p	ation; To	1 Yes 2 No F  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 A Inpatient 2 LE	R/Outpatient 28b. Time of Injury	28c. Injury Work?	4 Nursing Ho	ome 5 Reside 28d. Describe ho	nce 6 Other (Spew injury occurred	ecify)
DIVIS	ital or Atters after de ra all Directo	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (Str. City or Town	reet and Number or F , State)	lural Route Number,
	the Hospl nin 24 hou the Funer npletely fill	Medicai	one) 2 Medical Exami	sician: To the best of my know ner: On the basis of examination and manner stated.	on and/or invi	estigation, in my opi	nion, death occur	red at the time, da	ite and place, and du	e to the cause(s)
	5 Vit	-	29b. Signature and title of certifier	1.15.10		29c. License	number	29	d. Date signed (Mon	th, Day, Year)
7	0		30. Name and address of person who co	mpleted cause of death (Item:	23a) (Tyna P	rint)	-000	N	ovember	1,2006
	Sta Registr	te ar	29b. Signature and title of certifier  Andrew Kay: M 30. Name and address of person who co  Andrew Kay: The S 31. Date filed (Month, Day, Year)  NOV 1 3 2006	Tohns Hopkins Registrar's Signatu	Hospi	tal,6001	Vorth Wo	Ife Stra	et. Many 1	and 21205

		1 For State	State of Mary		artment of H			2006	35890
F 25 20 1	10.5%	Registrar  1. Decedent's Name (First, Middle, Last	)		tillicate of t	Jean	2. Date of Dea	-	3. Time of Death
Physi		Rosie Lea Young	7				Octobe:	Day Year r 15 2006	7:35 A M
/Med Exam		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Dea		4c. County of Dea	
<b>张考点员</b>		613 Quarry Av	/enue		Cap	itol Hei	ghts	Prince	George's
Funera	_	5. Social Security Number 6. Se	7. Ag <i>e (li</i>	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hr. Hours Min		h y, Year) 9. Bir Co	thplace (State or Foreign ountry)
Directo	r	577-46-5538 Usual Residence of Decedent	J 24.	73 Yrs.			Mar. 20		irginia
land ow		10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits
Many I sh	ţ	Maryland Prince (	eorge's		Canito	ol Heigh	tc		1 □XYes 2 □ No
h the	Director	10e. Street and Number	00180		10f. Zip Code	71 HCTEH		10g. Citizen of What Co	ountry?
th wil	ai	613 Quarry	Avenue			20743		United	States
r dea	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? ( n, Mexican, Pue	Specify Yes or No- nto Rican, etc.)	14. Race - Ame Black, Whit	
s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No If Yes, Give		1 ☐ Yes 2X No	Specify:			lack
III. X I X I 3-0030  be filed within 72 hours after death with the Maryland hall Hygiene. d other than "natural", or iteme 23s or 28s-f show event, the Medical Expriner must be notified at	ed b	15. Decedent's Edu	Year or Dates:	16a Decer	dent's Usual Occupa	ation		16b. Kind of Business	
nin 72	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed)	(Give	kind of work done of DO NOT use retired	during most of wo	orking	Tab. (tilla of basillosa	modestry.
d with	E	12th	College (1-4or 5+)		Office Ma	nager		Priva	te
al Hyg	Be	17. Father's Name (First, Middle, Last)				0	ame (First, Middle,		
Ments Ments	To	Carroll Edward	Tyree				Ethel Fi	cancis Weav	er
2 shr and is m		19a. tnformant's Name/Relationship (T)	,					r, City or Town, State, 2	Zip Code)
tand Health Im 27		Renee Valerie Yo	<u> </u>	20b. Place of Dispo	4 Lamont	Drive,	Lanham, N		T
Dailiniore, Mai yiaila ZIZIS-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural, or iteme 28s or 28s-f show any injury or other traumatic event, the Medical Examinat munit be notified at		Burial 2 Cremation 3 F	Removal from State	cemetery, crer	natory or other place	· .		20c. Location - City or	
iit. Partimetriant		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens			In Cemete Name and Addres			Brentwoo	
Dermii Depar Impor		1 200/1	Stournat	TIT "				Funeral Hom Vash., DC 2	
18 July 10 10 10 10 10 10 10 10 10 10 10 10 10		23a. Part1. Enter the disease, or compleshock, of heart failure. List only o	ications that caused the	death. Do not ent					Approximate
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/Medica	I .	resulting in death)	Due to (or as a co	Pulmonary	y Arrest				
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ecute and I-tran	Examin	that initiated events resulting in death) Last	Due to (or as a co	onsequence of):					
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ath certi	N/W	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of p					23d. Date of del	ivery
death death death	Physician/M	in the past 12 months? 1 Yes 2 No	1 Live birth 2 4 Pregnant at time		]Ectopic pregnancy ]Oth <i>er (specify)</i>	·		Month	Day Year
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is, r.O. DOX of the standing igned by the attending be detached for use as	by F	Part II. Other significant conditions con	-		nderlying cause give	n in Part I.	23e. Did to	bacco use contribute to	the cause of death?
w requires to been signed should be	ted	CHF, ALCD	, renal fai	lure			1 🗆 Y	es 2X No 3 Pr	obably 4 Unknown
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Attender r death	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	At home, farm, str			28f. Location (S	treet and Number or Ru	ıral Route Number,
s afte	Certification:	4 Homicide	building, etc. (5	specify)			City or Tow	n, State)	
To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending completely tilled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 X Certifying Phy (Check only 2 Medical Exemi	sician: To the best of m	y knowledge, death	occurred at the time	e, date and plac	e, and due to the c	ause(s) and manner as	stated.
the H in 24 the F nplete	Medical	Sile)	and manner stated.	annation and or in					
T Wilt	2	29b. Signature and title of certifier	a	01 -	29c. License		2	29d. Date signed (Monti	n, Dey, Year)
1/1	)	TOVI	v. vo	WE M		D27377		October	19, 2006
12 (0)		30. Name and address of person who co				vo 450	)9 Collo	ge Park, MI	20740
s	tate	31. Date filed (Month, Day, Year)	2. Registrar's		LETINOTE A	ve., 1130	,, corre	Se rark, I'll	, 20,40
Regis		OCT 2 0 2006	Klane	K Chan	(1)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien U 0 5 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Luigi Appareti 5:01 AM 2006 November 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Manor Care - Ruxton Towson Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1 X M 2 □ F 82 039-09-4133 November 3,1924 Massachusettes Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No Maryland **Baltimore** Pikesville 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code United States 21208 1840 Reisterstown Rd. Race - American Indian, Black, While, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Il Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Musician Music 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Sabina Quaglia Eugenio Appareti 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6412 Murray Hill Rd. Gloria K. Appareti/wife Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖫 Cremation 3 ☐ Removal from State
4 ☐ Qonation 5 ☐ Other (Specify) Greenmount crematory Nov. 11,2006 Baltimore, Maryland 21. Signature of Funeral Service Liseuse Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Raltimore, MD 21212 23a. Part. Enter the disease, or compiliations that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR THRUMBESIS Days Due to (or as a consequence of):

**Physician** /Medical

permit. Page Department o Important: If any injury or

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

Items 23s

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23.
Lry or other traumatic event, the Medical Examinant must

Baltimore, Maryland 21215-0036

Director

Be Completed by Funeral

**Examiner** the Hospital or Attending Physician: The law requires that the death certificate be executed

Physician/Medical Examiner Completed by To Be Medical Certification: after death.

Diractor: A
d in by the fu vithin 24 hours after To the Funerel Dir

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence.  Due to (or as a consequence)					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	I death 3 Ectopic p			23d. Date of de Month	livery Day Year
Part II. Other significant conditions  CORONARY					couse contribute to	o the cause of death?
EMPHYSO	Enjoy.			24a. Was an autopsy performed	? death?	utopsy findings available completion of cause of s 2 \(\text{\Omega}\) No
25. Was case referred to medical			26. Place of De	alh (Check only one)		
examiner? 1 \( \text{Yes} \) 2 \( \text{No} \)	Hospital: 1   Inpatient 2	ER/Outpatient 3 D	OA Other: 4 Jursing	Home 5 Residence	6 ☐ Other (Spe	ncify)
27. Manner of Death  1 Statural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury al Work? 1 \( \text{Yes} \) 2 \( \text{No} \)	28d. Describe how in	njury occurred	
3 Suicide 6 Could not to determined		ome, larm, street, factor	y, office	28f. Location (Street City or Town, St		ural Route Number,
	hysician: To the best of my kno miner: On the basis of examina and manner stated.					
29b. Signature and the ol certifier	loch		D-60 128		Date signed (Mon	
30. Name and address of person who	completed cause of death (Item		ER Dr.	Touser	170 3	21264

DHMH 17 Rev 1/2001

10

State Registrar 32 Registrar's Signature

4

31. Date filed (Month, Day, Year)

			For State		aryland / Depa	artmer	e ink. Ensure A nt of Health and I te of Death	Mental Hyg		06	35892
			<ul> <li>Registrar</li> <li>Decedent's Name (First, Middle, La</li> </ul>	st)				2. Date of Dea			3. Time of Death
	Physici /Medic	al		ndersen		4h Cih	, Town, or Location of Deat	Novembe		Yeer 2006 nty of Death	5:00 P M
	Examin					4b. City		(1			
			2926 Alconbury Co 5. Social Security Number 6.5		e (In yrs. last birthday)	If Unde	Abingdon or 1 Year If Under 24 Hrs	8 Date of Birth		rford	place (State or Foreign
	Funeral Director		075-12-1156	1000M 2□F	85 Yrs.	Months				Cou	ginia ginia
pu	3-5		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ncation					10d. Inside City Limits
5-0036 72 hours after death with the Maryland	of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23s or 28s-f show or other treumatic event, the Medical Examinar must be notified at	tor	Maryland Harfo	rd	Abingdon	Cation					1 □ Yes 2√2 No
the	128	by Funeral Director	10e. Street and Number			10f. Zi	p Code		l 0g. Citizen	of What Cou	ntry?
wit	380	<u>_</u>	2926 Alconbury C	ourt.		21	.009		USA		
deatl	ms 2	Jer	11. Marital Status	12. Was Decedent	Ever in U.S. 13.		edent of Hispanic Origin? (Secify Cuban, Mexican, Puer	pecify Yes or No-	14. F	Race - Ameri	
fter	Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items any injury or other treumatic event, the Medical Examination. Once.	Ψ	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 Types 2 If Yes, Give	No			to Hican, etc.)		Black, White,	etc.
ars a	- B	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	WWII	1 ☐ Yes	2XNo Specify:		Spe	cify: Mh	ite
od within 72 hours aft	an an	Completed	15. Decedent's E	ducation	16a. Dece	dent's Usu	ual Occupation		16b. Kind o	f Business/Ir	
27 0	- 9	olet	(Specify only highest gr	ade completed)	(Give	kind of wi DO NOT i	ork done during most of wo use retired)	rking			ŕ
i iš	the	E	Elementary/Secondary (0-12)	College (1-4or		-m-1	Manager		Come	struct	
peli	Hygi ther int, I		17. Father's Name (First, Middle, Last	)	negri	Juan		me (First, Middle,			LOn
nd 2 should be file	ad o	Be					T1	(1-)	m' 1	,	
plno	l Mer nark	P <sub>C</sub>	Halfdan (unk)	Andersen	405. 14-75		Ingebor		Eide		- 0 - 1 - 1
2 sh	and is r		19a. Informant's Name/Relationship			-	s (Street and Number or Ri		-		
and	n 27	1	Marion R. Anders	en/ Wife			conbury Court		•	_	
s -	i i		20a. Method of Disposition	7D	20b. Place of Dispo cemetery, cre	osition (Na matory or	ame of other place)	Date	20c. Location	on - City or T	own, State
Page	nt: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Speci	JHemovai from State fy)	Bel Air I	viemor	rial 11-	9-06	Rel Ai	r Ma	ryland
permit. Pages 1 a	ortent: injury ie.		21. Signature of Funer Service Lice		2:	2. Name a	nd Address of Facility				
	Depa Impo any i			mal	Mo	cComa	s Funeral Ho st Broadway,	me, P. A		3.0	
			23a. Pm1. Enter the disease, or con shock, or heart failure. List only		51	) wes	st Broadway,	Bel Air,	Mary.	Land 2	Approximate
1	hysician /Medical xaminer	ner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. METI Due to (or as	a consequence of):	PSLA	HDDER (URIA	IARY) C	AN CE	R	Onset and Death
te be executed	ysician and	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of):						
<b>•</b> 0	physis the	dica	•	d							
death cert	e atter	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	Ectopic p	pregnancy pecify)			Date of deliv Month	rery Day Year
	ed by the detached	P.	Part II. Other significant conditions	contributing to death t	out not resulting in the u	nderlying	cause given in Part I.	23e. Did to	bacco use c	ontribute to	the cause of death?
Les l	g ge	b		3		, . 3			es 2000		bably 4 □Unknow
requires	plnous	tea									
The law	has b	Completed						24a. Was a autop perfor	sy med?	b. Were autoprior to condeath?	opsy findings available ompletion of cause of
_ ::	certificate rector, pag	e C	25. Was case referred to medical	T			00 01	1 Yes		i Li Yes	€□ INO
Physicien:	is certific director,	20	examiner?	Hospital:			Other	ath (Check only or		0.1	· ·
. Syde	G S	10	1 ☐ Yes 2 No 27. Manner of Death	' 1 ☐ Inpati			OA 4 Nursing I	Home 5 AResid			ry)
Attending	After fune	ation	112 Natural 5 Pending 2 Accident Investigation	28a. Date of Inju (Month, Da	y Year) 286. Fime of Injury	M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	zod. Describe n	ow injury oc	curred	
UNISION OF VITAL DECOLUS,	within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not I 4 Homicide determined	280. Place of In	ury - At home, farm, st c. <i>(Specify)</i>	reet, facto	ry, office	28f. Location (S City or Tow	treet and Nu n, State)	imber or Rur	al Route Number,
Hospi	e Funet letely fill	edical			f examination and/or in		d at the time, date and place n, in my opinion, death occ				
Toth	within 24 h To the Fur completely	Me	29b. Signature and title of certifier	Nowak	ens li, K	1 29 7	Oc. License number	5	29d. Date sig	ned (Month,	Day, Year) 7 2006
71-			30. Name and address of person who	completed cause of	death (Item 23a) (Type	Print)	1Ann St.	R. 14	-200	111	21014
	Sta	ite	Andrew Not 31. Date filed (Month, Day, Year)	OOKOUSK 32. Regist	rar's Signature	Jane H	11th Dt.	DUA	nr,	1412	2101/
	Regist		NOV 1 4	200b ASS	140 AS 13	AS TO					

DHMH 17 Rev 1/2001

Anderson

Harried

			1- State of Maryland / Department of Health and Certificate of Death		ien@ () () 5	35893
			Decedent's Name (First, Middle, Last)	2. Date of Deat		3. Time of Death
	Physic		Virginia Helen Alt	November	Day Year 10 2006	7:30 A. M
	/Medi Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of De		4c. County of Dea	
	LAGIIII		1505 Sycamore Street Baltimore		N/A	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H	Irs. 8. Date of Birth	,	thplace (State or Foreign
	Director		214 46 1460 1 M 2 T F 60 Yrs. Months Days Hours M	lrs. 8. Date of Birth (Month, Day, April 20	5, 1946 Ma	ountry) ryland
	p .		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			1
	sho	5				10d. Inside City Limits 1     1
	286-1	ectc				
	with the man	Funeral Director	106. Street and Number 10f. Zip Code 21226	10	g. Citizen of What C U.S.	ountry?
	eath	era		(Specify Vec or No	14. Race - Am	erices ladies
40	ter d	E.	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married  12. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	erto Rican, etc.)	Black, Whi	te, etc.
336	urs a		3 ☐ Widowed 4 ☐ Divorced If Yes, Give 1 ☐ Yes 2 ☒ No Specify:		Specify: Wh	nite
Ö	72 hours after death with the Maryland Incturel, or Items 23a or 28e-1 show Jical Ext. off set. ust be notified at	Completed by	15. Decedent's Education 16a. Decedent's Usual Occupation	11	6b. Kind of Business	/Industry
215	within 7 ene. then "r	ble	15. Decedent's Education (Specify onfy highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of work done	working		
2	filed withii Hygiene. other then ent, It e M	Son	Secondary (0-12) College (1-4or 5+) Homemaker		Own Hon	ne
pu	be file	Be		Name (First, Middle, N	laiden Sumame)	
yla	2 should be and Mental Is marked of sumatic eve	ို		len Oxley		
Maryland 21215-0036	2 sh and is m		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or			
	1 and 2 Health tem 27 I		Robert Alt / Husband 1505 Sycamore Street	-	re, Maryla	
Baltimore,	of of		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)		Oc. Location - City or	
tim	Part of the Part o				Baltimore,	
Bal	permit. Page Department Importent: I eny injury o			Gonce Fund		
			4001 Ritchie High			yland ZIZZS Approximate
			23a. Pl/11. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardi shock, or theart failure. List only one cause on each line.	_	st,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  a. LOWER EXTREMITY Gang	rene		
	Examiner		Peripheral Vascular	Dicens	0	
		er	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):	UISEUS		
	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c Cor Pul monale			
oʻ	exec an an rial-tr		resulting in death) Last Due to (or as a consequence of):			
58760,	cate be executed physician and the burial-transit	dlcal	Co COPD			
_		O I	IF FEMALE:			
Вох	death certifi e attending id for use as	an/h	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date ol de	*
	0 0	SICI	1 Yes No 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
P.0	that the de ed by the detached	Physician/M	3 DOMINOWIT	1		
ls,	Se un	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			the cause of death?
Vital Records,	w require been signature	eted	Diane 2 Diane 12	- 1 ☐ Yes	2 No 3 □ P	robably 4 Unknown
Sec	e law has b	Completed	Bipolar Disorder	24a. Was an autopsy	prior to	utopsy findings available completion of cause of
<u>=</u>		Ö	1	perform 1 Tes 2	ed? death? XNo 1☐Yes	2 □ No
Zi:	Physicien: The It this certificate ha ral director, page 2	Be	examiner?	eath (Check only one		
of	Physral di	. To	1 Yes 2 No Prospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing 27. Manner of Death 28a. Date of Injury 28b. Time ol 28c. Injury at	Home 5 Resider  28d. Describe how		cify)
	ding h. After funer	tion	1 Matural 5 Pending (Month, Day Year) Injury Work?	20d. Describe nov	ringary occurred	
Division	Attending or death. sctor: After by the fune.	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Stre	et and Number or Ri	ural Route Number.
Ď	of or Attends after death	erti	4 ☐ Homicide determined building, etc. (Specify)	City or Town,	State)	
	e Hospitel or Atten 24 hours after deat e Funerel Director: letely filled in by the	alc	29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and plan	ice, and due to the cau	use(s) and manner as	stated.
	he Ho in 24 he Fu	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	curred at the time, dat	e and place, and due	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier 29c, License number	29	d. Date signed (Mont	h, Day, Year)
) .	$\prec$		MD USG3	25	11/10/0	le
6	I		30. Name and addresse of person who completed cause of death (Item 23a) (Type, Print)	11	101	110 0:0
V			Erika N. Kane, MD 4115 Ritchie	Hwy !	nooklyn	MD 21225
	⊸ Sta Registr		31. Date liled (Month, Day, Year) 32. Registrar's Signature	,	,	

			For	State of Maryland	/ Department of Health and M	Mental Hygie	ne no c	25001
			1 - State Registrar		Certificate of Death	Reg.	NO. UUD	35894
	Physic	ian	Decedent's Name (First, Middle, Las	"	1	2. Date of Death Month	Day Year	3. Time of Death
· QL	/Medi	cal	King U	) Grain		Novembe		6 09,47 m
J.	Examir	ner	4a. Facility Name (If not institution, give	, 1	4b. City, Town, or Location of Death	The second	4c. County of Deat	1) / h-
	Funeral		5. Social Security Number 6. Security Number	ex 7. Age (In yrs. Jas	if birthday) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	O Pin	hplace (State or Foreign
	Director			ØM 2□F 69	Yrs. Months Days Hours Min.	(Month, Day, Ye	927 500	ountry)
	pu ,		Usual Residence of Decedent			140.101	101 004	771 0 170-21701
	anyla shov	<u>_</u>	10a. State 10b. County	10c. City, 1	Town or Location	0= 1	/	10d. Inside City Limits
	the M	Director	10e. Street and Number	IA	XOALTIMON	KE CIT	4	1ÆYes 2□No
	with I		10e. Street and Number	TH STORE	10f. Zip Code	109.	Citizen of What Co	ountry?
	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dissal Examitier must be notitled at	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Ame	T .
9	or Iter		1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 ☐ Yes 2.X.No	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	
21215-0036	ral', c	1 by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify:	ACK
5-0	n 72 hours "natural", edical Ex	Completed	15. Decedent's Ed (Specify only highest grad	ucation 1 de completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work	16b	. Kind of Business/	industry
121	d within giene. ir than	E E	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)		. بدر مسم ، بدر	
	be filed v tal Hygie d other t		17. Father's Name (First, Middle, Last)		MECHANIC		ELF-EM	DPLOYED
an	e d fa	o Be	GAMBIE	12	Phala Va-	e (First, Middle, Maid	en Sumame)	e n a
Maryland	s 1 and 2 should f Health and Men Item 27 Ie marke other traumatic	2	19a. Informant's Name/Relationship (7	ivpe, Print)	19b. Mailing Address (Street and Number or Run	A Boute Number Cit	ty or Town State :	OAR In Code)
Š	alth a 27 le		AMIL BRAND	(DAMG-HTT-R)	3810 GREENIMUNT	- AVE ADT	- BAL	1 MA 2/2/5
Je,	ges 1 a t of Hea if Item or othe		20a. Method of Disposition		e of Disposition (Name of etery, crematory or other place)	Date / 20c.	Location - City or	Town, State
Ē	Pages nent of I nnt: It Its ury or o		1/△ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	nemoval from State	CAR MEI CEME 11-1	7-06 9	BAITIN	DE MA
Baltimore	permit. Pag Department Important: II any injury o		21. Signature of Funeral Service Licens	iee	22. Name and Address of Facility	Parials	TP FULL	Echi Home
	Dep de de de de de de de de de de de de de		1 Dietuch	N. William	D 2948 N. FULTO	NAVE	BALTO,	MO. 21217
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only or	lications that caused the death. In ecause on each line.	Do not enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Myo Cu	sechal FAR	we Fr	1)	Onset and Death
	/Medical Examiner		Tooling in doubly	Due to for as a consequen	ce of):			enter
	jk.	er	Sagrentially list conditions if any leading to immediate	b Due to (or as a consequen	ice of):			
	uted 3 ansit	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
oʻ	exec en an rial-tr	Exa	resulting in death) Last	c Due to (or as a consequen	ce of):			
38760	icate be executed physicien and s the burial-transit	dicai		d				
	ing pt	a) I	IF FEMALE:					
Вох	ath co	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de	ath 3 ☐ Ectopic pregnancy	10	23d. Date of deliv	
P.O.	the a	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐ Unknown	5 Other (specify)		Month	Day Year
۵.	thet the death certif ed by the attending detached for use er	P	Part II. Other significant conditions co	ntributing to death but not resulting	og in the underlying cause given in Part I	23e Did tobacco	O Usa contributo to	the cause of death?
Division of Vital Records,	8 <u>15</u> 8	0	NECK	CANEL	1			bably 4 Unknown
S	w requires been sistemand to	Completed				24a. Was an	24h Mara aut	anny findings available
æ	The la	E				autopsy performed?	prior to co	opsy findings available ompletion of cause of
<u>ta</u>	an: tifice tor. p	4	25. Was case referred to medical		26. Place of Death	1 Yes 2 Y	No 1 ☐ Yes	2□ No
>	Physician: The lav this certificete hes al director, page 2	To B	examiner?	lospital: 1   Inpatient 2   ER/	Other	me 5 Residence	6 □Other (Spec	thr)
0	ding PP		27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)		28d. Describe how in		(4)
20	eath. or: A the fu	catic	2 ☐ Accident investigation		M 1 Yes 2 No			
Ž	or Attendent efter death Director: in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rur	al Route Number,
	pital purs e eral E		000 000000					
	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	ner: On the best of my knowled ner: On the basis of examination and manner stated.	dge, death occurred at the time, date and place, a and/or investigation, in my opinion, death occurr	and due to the cause( ed at the time, date a	s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	and marries stated.	29c. License number	29d. D	Date signed (Month,	Day, Year)
			12 plu	adh	2 M 1 1991	8 11	111	1200 (0
1	7	-	30. Name and address of person who co	empleted cause of death (Item 23)	a) (Type, Print)		/ /	/
1			2000 ( )21	potts	next Balts	next	MA	ic land
	Sta		31. Date filed (Month, Day, Year)	32. Pagistrar's Signature	Links			1
	Registra	ar	NOV 1 4 20	UD JERON ST	The same of the sa			

			1 - For State Registrar	State of Maryland /		artment o		d Men		2006	35895
			Registrar  1. Decedent's Name (First, Middle, Las	· e)	Cei	uncate c	Dealii	2.1	Reg Date of Death	. No:- U U U	
	Physici	an	2.1			BAR.	JES		Month	Day Year	
	/Medic		4a. Facility Name (If not institution, give	street and number)			n, or Location of De		<b>WEMPER</b>	4c. County of Dea	
	Examir	er		okins Hospital		2 11	_ /	7	i	N/4	
	Funeral		5. Social Security Number 6. Se		oirthday)	If Under 1 Ye			Date of Birth	9. Bir	thplace (State or Foreign
	Director		198-54-3688 1	□M 20F 41	Yrs.	Months Da	ys Hours M	lin.	Month, Day, Y	1965 C	YORK PA
	<b>b</b>		Usual Residence of Decedent								7
	arylar ehov	_	10a. State 10b. County	10c. City, To		cation					10d. Inside City Limits
	Me M	Director	PA YOR	K E++	215						1 Yes 2 No
	with t	ā	10e. Street and Number			10f. Zip Cod	θ - 2		10g	J. Citizen of What C	ountry?
	se 23	eral	100 Wedge Wood	12. Was Decedent Ever in U.S.	142.1	Was Danadari	319	/Canada	V N-	USA	
	ter d	Š	11. Marital Status  1 Never Married 2 Married	Armed Forces?	13. 1	Yes, specify C	of Hispanic Origin? Cuban, Mexican, Pu	erto Rica	n, etc.)	14. Race - Am Black, Whi	
930	urs at	by F	3 □ Widowed 4 □ Divorced	1 XYes 2 □ No WYes, Give Year or Dates:		I□Yes 200	No Specity:			Specify:	h:+2
21215-0036	filed within 72 hours after death with the Maryland Hygiene. wther than "natural", or Items 23a or 28e-f ehow ent, the Medical Examinat must be notified at	Completed by Funeral	15. Decedent's Ed		a. Deced	lent's Usual Oc	cupation		16	b. Kind of Business	Vindustry
2	thin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	NOT use re	ne during most of v tired)	working			
2	gien er th	Son	12+1		S	upervi	50-			CONSTRU	ction
2	al Hy	Be	17. Father's Name (First, Middle, Last)				18. Mother's N	Name (Fir	st, Middle, Ma	iden Surname)	
yla	Ment Ment arke	ဥ	Samuel E.	Barnes			1 14a	24	Hoff	Master-	
Maryland	2 sh and is m		19a. Informant's Name/Relationship (7	1	9b. Mailin	g Address (Str	eet and Number or	Rural Ro	ute Number, C	City or Town, State,	Zip Code)
	and lealth m 27 her to		Stevie N. Barns		000	Edge	sood Cir	cle	Etter	s, PA I	7319
Ö	ges If of the		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	cemet	on cron	sition (Name of natory or other	niaca)	Date	20	c. Location - City or	Town, State
Baltimore,	t. Pa rtmen rtant:		4 □ Donation 5 □ Other (Specify		CLEIN	Direct Sei		(11/0		YORK PA	17401
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f ehow any injury or other treumatic event, the Madical Examinar must be notified at once.		21. Signature of Funeral Service Licen	500			dress of Facility		man-H		eral Home
			23a. Part 1. Enter the disease, or comp	Dications that caused the death. De		240 Re					Md 21215 Approximate
			shock, or heart failure. List only of Immediate Cause (Final	one cause on each line.	J HOL GILL	or the mode or	:	nac or res	phatory arrest		Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	a Stage II B	17	norca	tic Cay	CER			le months
П	Examiner			Due to or as a consequence	e of):						
		e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence	e of):	-					7
13	d d ansit	Examin	Cause (Disease or injury that initiated events								0
o O	en an rial-tr	Exa	resulting in death) Last	Due to (or as a consequence	e of):						
8760,	icate be executed physicien and s the burial-transit	dicai		d.							
9	ing pl	0	IF FEMALE:						750		
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal dea		Ectopic pregna				23d. Date of de Month	livery Day Year
o O	es thet the death certifications to the attending to be detached for use as	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□ Unknown	5∟	Other (specify	)				52,
О. О.	thet the	P	Part II. Other significant conditions of	ontributing to death but not resulting	in the ur	deriving cause	given in Part I		23e. Did tobar	co use contribute to	the cause of death?
Division of Vital Records,	The law requires thet the death certifi ste has been signed by the attending page 2 should be detached for use as	d by				, ,					robably 4 Dunknown
Ö	w requir been si should	iete						-	24a. Wasan	24h Word a	stancy findings available
Be B	he lav e has	Completed						-	autopsy performe	d?   death?	utopsy findings available completion of cause of
ta	ifficet or, pe		25. Was case referred to medical				26. Place of D			No 1 □ Yes	2 □ No
<u>=</u>	Physician: r this certific ral director,	To Be	avaminar?	Hospital: 1 Manpatient 2 ☐ ER/C	Outpatien	3□ DOA	Other			e 6 □Other (Spe	oshi)
0	g Ph		27. Manner of Death	1	. Time of		njury at Nork?			injury occurred	,,
Ö	ath. ar: Af	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		прогу		☐Yes 2☐No				
<u>Š</u>	or Atter de Directe	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, offi	сө	28f. L	ocation (Stree	et and Number or Ri State)	ural Route Number,
Ω	rs aft										
	To the Hospitel or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificete his completely filled in by the funeral director, page	Medicai	29a. Certifier 1 S Certifying Phy (Check only one) 2 Medical Exam	ysician: To the best of my knowled iner: On the basis of examination a and manner stated.	ge, death ind/or inv	occurred at the estigation, in m	e time, date and pla ny opinion, death oc	ce, and c curred at	fue to the caus the time, date	se(s) and manner as and place, and due	s stated.  to the cause(s)
	To the Hospitel within 24 hours a To the Funeral Completely filled	Me	29b. Signature and title of certifier			29c. Lice	ense number		29d.	. Date signed (Mont	h, Day, Year)
)			1 Affille	7		RES	5-000		N	OVEMBER	9 2006
	10		30. Name and address of person who o	0	-	Print)					
	ì		Jole Philler	1 600 N. I	20	Ife St	Bouth	more	; M12	21287	
	Sta Registr	-	31. Date filed (Month, Day, Year)	32 Registrar's Signature	11 m	Farrage					
			NOV 1 4 200	10 Sidney Br	Plant	1000					

DHMH 17 Rev 1/2001

**ORIGINAL** 

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November **Physician** Donna Rae Bruneau 2:30 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 3864 Colwyn Drive Jarrettsville Harford If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗘 F 214-28-7086 75 Yrs. Director April 28.1931 PA Usual Residence of Decedent nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artiment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, "as Medical Examine must be notified at 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 ☐ Yes 2 No Director Harkord Jarrettsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3864 Colwyn Drive 21084 u.s.A. Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Aerospace Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Floyd R. Garland Thelma Heckman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Guu A. Bruneau (husband) 3864 Colwyn Drive, Jarrettsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ØBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 11/16/2006 Owings Mills, MD 4 □Donation 5 □Other (Specify) Garrison Forest VA <sup>22</sup> Name and Address of Facility Schumunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Rd., Bel Air, MD 21014 21. Signature of Funeral Service Livense 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician MULTIPLE /Medical **Examiner** to the Hospital or Attending Physician: The law requires that the death certiticate be executed Division of Vital Records, P.O. Box 68760

Sequentially list conditions, if any, leading to immediate cause. Enter this original Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect.  Due to (or as a consect.)  Due to (or as a consect.)		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 □Ectopic pregnancy	23d. Dale of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not re	sulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Munknow
			24a. Was an autopsy performed?  1 □ Yes 2 ☒ No 1 □ Yes 2 □ No
25. Was case referred to medical examiner?		26. Place of	Death (Check only one)
1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	□ ER/Outpatient 3 □ DOA Other: 4 □ Nursir	ng Home 5 X Residence 6 Other (Specify)
27. Manner of Death 1 ØNatural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Injury (Month, Day Year) on	28b. Time of Injury at Work?  M 1 Yes 2 No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		nome, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying F	hysician: To the best of my kn	owledge, death occurred at the time, date and p	lace, and due to the cause(s) and manner as stated.

DHMH 17 Rev 1/2001

State

Registrar

within 24 hours a To the Funaral C

of person who completed cause of death (Item 23a) (Type, Print)

32. Rigistrar's Signature

P. EDWARDS, M.D.

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Month

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Physicia /Medic Examin	ai
Funeral	

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or items 23a or 28a-f show any lijury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

The law requires that the death certificate be executed attending physician and for use as the burial-tra Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: neral Director: , filled in by the f

CORNELIA DRISCOLL November 10, 2006 BOYLE 11:00AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) March 10,1918 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 🗌 M Director 216-52-6961 88 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 □Yes XXNo Director Maryland Baltimore Towson 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 615 Chestnut Avenue 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXX No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married
Widowed 4 Divorced 1 ☐ Yes XX No Specify þ Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Leasing Agent Apartments 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Cornelius Driscoll Jessie Lawrence White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deeley K Nice Jr POA Farnham Way Timonium Maryland 21093 20a. Method of Disposition

1 Burial 2 XXremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State GreenMount Crematory 11/11/06 4 Donation 5 Dother (Specify) Baltimore, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Fun. Hm. Inc. signature of Funeral Service License 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cay e on each line. Approximate Interval Between Onset and Death Immediate Cause (Final bstructive disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, listly hading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1∐ Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. uns 30. Name and address of person who completed cause of death 4 Balto, Md 2, 205 60

Registrar

31. Date filed (Month, Day,

32. Registrar's Signature

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2006

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		•	For State Registrar		State of	Maryla	nd / Dep <i>Ce</i>			lealth <i>Deatl</i>		lental Hy	giene Reg. No	006	358	398
	/sicia		1. Decedent's Name (First, Midde Margaret Ros		liko							2. Date of De Month		2006	3. Time (	
	ledica amine	r	4a. Facility Name (If not institution	on, give st	reet and num			4b. Cit	y, Town, o	r Location	of Death			unty of Deat		
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Fun Direc			5. Social Security Number 213-48-6663	6. Sex	м 2√2 F	7. Age (In yr:	s. last birthday Yrs.	Month	ler 1 Year s Days	If Unde Hours		8. Date of Bi (Month, Di Mar. 7	rth a <i>y, Year)</i> , 1913	9. Birt Penr	hplace (State untry) ISYIvar	or Foreign nia
and	4	ŀ	Usual Residence of Decedent  10a. State 10b. Count	·		10c. C	City, Town or L	ocation							10d. Inside (	City Limits
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36 rs afte	T I	by F	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce		1 ☐ Yes 2 If Yes, Give Year or Da	9		1 🗆 Yes	2 <b>≱</b> No	Specify	y:		St	ecify:		
5-0036 72 hours after death with the Maryland nature!; or iteme 23a or 28s-f ehow	8	ed ed	15. Decede	nt's Educa	ation		16a. Dece	dent's Us	sual Occup	pation			16b. Kind	of Business/	nite	
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "naturel", or iteme 23a or 28a-1 ehow	eny inju	1	21. Signature of Funeral Service	Licansee	11/10		+ M	2. Name	and Addre	ss of Faci	ily II om	0 D 7	Variet	iicre,	rruyto	4.53
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1-	For State Registrar

State of Maryland / Department of Health and Mental Hygiene

			Registrar				Certi	ificate	of L	Death			Reg	No.			
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	xamin		4a. Facility Name (If not institution,	give street and n	umber)		1	4b. City, To	₩n, or	Location	of Death	INOV.			y of Death	11100 11	_
			22 Clarendon A	7e .				Pikes	v i 1	16				Ra1	timor	۵	
Fu	ineral			6. Sex	7. Age	(In yrs. last birth	day)	If Under 1 Y	'ear	If Under		8. Date o	f Birth			lace (State or Foreig	n
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wit	38 0	Funeral Director	22 Clarendon A	ve.					212	808			U.	S.A.		•	
deatl	2 E	era	11. Marital Status	12. Was De	cedent E	ver in U.S.	13. Wa	as Deceden	of His	spanic Or	igin? (Spe	ecify Yes o	r No-	14. Rad	ce - Americ	an Indian	-
d je	흔	Fū	1 Never Married 2 Marrie	Armed f d 1 ☐ Yes	2 X N	0		as Deceden es, specify X		n, Mexicai	n, Puerto	Rican, etc.	)	Bla	ck, White,	etc.	
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Maryland 21215-0035 d 2 should be filed within 72 hours aff th and Mental Hygiene.	Tage	-	19a. Informant's Name/Relationshi	p (Type, Print)		19b. N	lailing	Address (Si	reet au	nd Numbi	er or Rura	I Route No	imber C	ity or Town	State Zin	Codel	
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Certificate be executed	use as the burial-transit	n/Medical		d													
Liftica O	ast	Ned	IF FEMALE:										-	T	1.1		
		20	23b. Was decedent pregnant	23c. If yes, or 1□Live		of pregnancy ! ☐ Fetal death	3□E	topic pregn	3001					23d. Da	te of delive		
death	od fo		in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at t	ime of death		ther (specif						Mo	onth	Day Year	
at the	stached for	Ę.	9 Unknown														_
	be det	by Physicia	Part II. Other significant condition	s contributing to	death but	t not resulting in th	e unde	erlying cause	e giver	n in Part I.		23e. D	id tobac	co use cont	tribute to th	e cause of death?	
he law requires t	should b	Pa										1	☐ Yes	2 19 No	3 🗌 Proba	ably 4 Unknown	
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r and and and and and and and and and and	2962	Ĕ						<del></del>				a	utopsy erformed	1	prior to con death?	pletion of cause of	١
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l or Attending efter death.	i by	Certification;	4 ☐ Homicide determin	200. Fidu	ding, etc.	y · At home, farm (Specify)	street	, factory, off	ice		2	81. Location City or	n (Street Town, S	tand Numb ate)	oer or Rurai	Route Number,	
pital urs e			00-0-4			85. 10.721.00	1000	DEN MARKETON	DVIE 45								1
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To the within 2	complet	Ned		and mai	nner state	ed.											
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15			Of Marin	11/2					1	141	16/			11/13	106		
40			30. Name and address of person w				pe, Pri	nt)									
l				m.0 21	700		r, F	7,400	Ow	ings 1	1115,1	70 2	1117				111
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Willie Boone

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			for State Registrar		State of Ma	ryland /	Certific			i wentai F	Reg. No.	11116	35900
	Physic	ian		ne (First, Middle, Last	-5	_				2. Date of Month	Death Day	y Year	3. Time of Death
	/Medi	cal	Willie			<u> </u>		O: -		Nove		1,200	
	Examiı	ner	Sina		1 of Balt	Himor	es	2 / 1 5	or Location of De	City		County of De	
	Funeral Director		5. Social Security 247-68	10	x 9-M 2□F 7. Age	(In yrs. last I		ths Days		in. (Month,	Day, Year)		irthplace (State or Foreigr Country)
			Usual Residence			61				10	173	39	SC
	irylan ihow	_	10a. State	10b. County		10c. City, To	wn or Location						10d. Inside City Limits
	Ba-f	cto	MD	NA		Balt	imore						1√ Yes 2 □ No
	with th	급	10e. Street and Nu				101	. Zip Code			10g. Citiz	zen of What C	
	eath ve 23	era		rginia A	Ve 12. Was Decedent E	una in II C	10.14 5		1215	/0		U.S.	
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mentat Hygiane.  If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Modical Examinar must be notified at	by Funeral Director		ried 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	Armed Forces?  ☐ Yes, specify Cuban, Mexican, Puerto ☐ Yes, Give  1☐ Yes, 2☐ XNo Specify:						14. Race - Am Black, Wh Specify: B	ite, etc.
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_	1 and 1ealth im 27			isbon-Si	ster		3317 \ of Disposition		nia Ave				215
Baltimore	permit. Pages 1 and 2: Department of Health at Important: If Item 27 ie any injury or other trau		20a. Method of Dis Burial 2	Sposition ☐ Cremation 3 ☐ F 5 ☐ Other (Specify)	Removal from State	cemet	tery, crematory	or other pla	· .	Date		cation - City o	
Ē	it. Partmer			5 Other (Specify) uperal Service Licens		King				1/11/0	Ran	dalls	town, Md
Ba	permit. Departr Imports any inju		21. Signatura du	MAIN	Maria	MA	Marc	ch F/	ess of Facility H West ash Ave			e, Ma	21215
	Physician /Medical Examiner	er	mmediate Cause disease or conditions resulting in death)	on contitions	ne cause on each line	astatio	e of):		ng, such as cardi		/ arrest,		Approximate Interval Between Onset and Death  YECLV
68/60,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dical Examiner	cause. Enter Und Cause (Disease or that initiated event resulting in death)	erlying r injury s Last	Due to (or as a	consequence	e of):						
P.O. Box	at the death certificate b by the attending physic tached for use as the b	Physician/Medical	tF FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknown	2 months?	3c. If yes, outcome of 1□Live birth 2 4□Pregnant at ti 9□Unknown	Fetal deal	th 3 ⊟Ectop 5 ⊟ Other	ic pregnanc r <i>(specify)</i>	у		2	3d. Date of de Month	elivery Day Year
v,	res that igned k be deti		Part II. Other signi	ificant conditions cor	ntributing to death but	not resulting	in the underlyi	ng cause giv	ven in Part I.	23e. Di	d tobacco us	se contribute (	to the cause of death?
ğ	w require been sig should b	edt	Atrial	fibullation.	Smoking					1 6	Yes 2	<b>8</b> 46 3 □ P	robably 4 Unknown
of Vital Records,	e lawre has beo ge 2 sho	Completed by			0					24a. W		24b. Were a	utopsy findings available completion of cause of
ř		ĕ								pe	topsy rformed? 2 1 No	prior to death?	
Ta Ta	sician: Th certificate irector, pag	Be	25. Was case refe examiner?	rred to medical			9.50		26. Place of D	eath (Check onl	-		
	sir dilib	은	1 ☐ Yes 2 ₩	110	lospital: 1 Inpatient			DOA		Home 5 ☐ Re	sidence 6	☐Other (Spe	ecify)
Sion	ending P eath. or: After I	Certification:	27. Manner of Dea 1 Natural 2 Accident	5 Pending investigation	28a. Date of Injury (Month, Day	Year) 28b.	Time of Injury M	28c. Injui Woi 1 [	ry at rk?  Yes 2 □ No	28d. Describ	e how injury	occurred	
Division	ital or Att rs after d al Direct led in by I	Certifle	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injury building, etc.	y - At home, (Specify)	farm, street, fac	ctory, office		28f. Location City or 1	(Street and own, State)	d Number or R	Bural Route Number,
	To the Hoepital or Attending Pr within Z4 hours alter death. To the Funeral Director: After it completely filled in by the funeral	edical	29a. Certifier (Check only one)	2 Medicat Exami	sician: To the best of ner: On the basis of e and manner state	my knowledg xamination a ad.	ge, death occur and/or investiga	red at the til	me, date and place opinion, death oc	ce, and due to the curred at the time	e, date and	and manner a place, and du	s stated. e to the cause(s)
	To t To t	Σ	29b. Signature and	title of certifier	1 1			29c. Licens	se number		29d. Date	signed (Mon	th, Day, Year)
	^		1 ( Ka	itha Il	osh MI	2		RE	5-000	9	Nov	1embe	r 7,2006
	1		30. Name and add	ress of person who co	empleted cause of dea	ath (ttem 23a	(Type, Print)	11 1	C =	14	77		
ستر	V		31 Data filed (Man	a Ghost	200	Sina	Marcal	Pital	ot Ba	MINIMOR			e to the cause(s) th, Day, Year) The Figure 1. The cause(s)
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	mit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
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aryland 212	should be filed withi
Itimore, Ma	it. Pages 1 and 2
	altimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		Please 1	Type or Print in Bla				_	_	ible.	
		1 - State Registrar	State of Maryland		artment of H rtificate of L		-	giene Reg. Na20	06	35901
Physici /Medic		1. Decedent's Name (First, Middle, Last Charles H.	Bollinger Jr	•			2. Date of Dea Month	Day	14 200	3. Time of Death
Examin		4a. Facility Name (If not institution, give Northwest Hos				Location of Death	'n	1	ty of Death	imore
Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs. last	t birthday)	If Under 1 Year	If Under 24 Hrs.				imore place (State or Foreign
Director		215-03-0595   ■ Usual Residence of Decedent	2M 2□F 86	Yrs.	Months Days	Hours Min.	8. Date of Birt 7 / 13	1920	Mar	place (State or Foreign ntry) yland
ryfand how		10a. State 10b. County	10c. City, T	own or Lo	ocation					10d. Inside City Limits
he Ma 8a-f e	ector	MD Balti	more		Baltimor	:e				1 □ Yes 2≹ No
should be filed within 72 hours after death with the Maryland and Mental Hygiene. The Maryland of Mental Hygiene 10 them 20 to 10 the Maryland marked other than "netural", or iteme 20 to 10 the Madical Examiner must be notified at unatic event.	Funeral Director	10e. Street and Number 6825 Camp Hill	Rd. 1F		10f. Zip Code	21207		10g. Citizen of US.		ntry?
r death	nera	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of Hill If Yes, specify Cubar		ecify Yes or No-		ice - Americack, White.	
rs afte	by Fu	1 ☐ Never Married <b>2</b> ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates:	1	1 □ Yes <b>2√⊡</b> No	Specify:	, 0.0.,	Speci		white
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within no.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done d DO NOT use retired nt Manac					e City r Divisio
filed v Hygie other i	0	17. Father's Name (First, Middle, Last)		LIA		18. Mother's Name				
wuld be Mental arked atic ev	To B	Charles H. B	ollinger			Kat	hryn E	Becket	t	
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Pages 1 and the strain of the		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State 20b. Place	e of Disno	sition (Name of natory or other place OSATY etery	1 .		20c. Location	- City or To	
permit. F Departm Importar eny injur		21. Signature Juneral Service Licens		22	Name and Addres Vans Fur	s of Facility	-			rford Rd.
80 5 9	_	Motest Och	4	A	nd Crema	ition Se	napel ervices	Par	kvil.	1e MD 21234
Physician		3a Part 1. Enter the disease, or compleshock, or heart failure. List only or Immediate Cause (Final	•			), such as cardiac (	or respiratory ari	rest,		Approximate Interval Between Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a consequen	S/1/2 ce of):	XX.		-			24 Itaris
Examiner	_	Sequentially list conditions,	Due to (or as a consequen	MI	DIAL INF	ARCTION	V		L	
uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. CORONAN							
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icate b physic s the bi	dicai		d						-	
leath certificate be attending physical for use as the bear to the bear the	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy	,	le			23d. Da	ate of delive	эгу
The law requires that the death certificate tie has been signed by the attending phys bage 2 should be detached for use as the	Physician/Medic	in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal de 4 Pregnant at time of death 9 Unknown		Ectopic pregnancy Other (specify)			M	onth	Day Year
as as as a sea a s	ρ	Part II. Other significant conditions con		g in the ur	nderlying cause give	n in Part I.				ne cause of death?
w require been sl should I	eted	ABDUMINAL ADRIT						es 2 No	3 Prob	
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ysician: Th is certificate director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	tospital:		Othe	26. Place of Death				
Attending Physician: r death. ector: Affer this certifica by the funeral director.	$\mathbf{H}$	27. Manner of Death	1 Lennpatient 2 LEH	Outpatien  b. Time of Injury	1 JU DON	4 Indising Ho	me 5 Residence R			v)
Attendin death. ctor: Aff	catlo	1 Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day 16a)	Hijury		es 2 No				
ofter d Direct Jin by	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	eet, factory, office	:	28f. Location (Si City or Town	treet and Numi n, State)	per or Rura	l Route Number,
To the Hospital or Attending Phywithin 24 hours efter dath. To the Funeral Director: After the completely filled in by the funeral	edical C	29a. Certifier 1 Certifying Physical Examination (Charles only one)	sician: To the best of my knowled ner: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the time restigation, in my opi	e, date and place, a inion, death occurr	and due to the c ed at the time, d	ause(s) and mi late and place,	anner as st and due to	ated. the cause(s)
Neithin To the	Me	29b. Signature and title of certifier	)		29c. License		2	9d. Date signe	ed (Month, i	Day, Year)
		* Milialist &	eve		1.74	15931		Novem	bor.	13142006
1xt		30. Name and address of person who co	Marca non	а) (Туре, I	Print)	ht Aver	nua Ba	altmo	6 M	13th 2006
Sta Registra		31. Date filed (Month, Day, Year) NOV 1 4 2006	32. Registrar's Signature	650	les .					

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Clarence Dilworth Brown 09,2006 12:25 P.M. November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9 Roosevelt Street Timonium Baltimore County If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1₫M 2□F 85 214-16-8226 Yrs. Director 14,1921 Phoenix,MD Usual Residence of Decedent deeth with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits •how r 28a-f ehow 1 ☐ Yes 2 No Maryland Baltimore County Timonium Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code r then "naturel", or Iteme 23a or the Medical Exercitive must be 9 Roosevelt Street 21093 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗹 No Specify: Specify: White ۵ 3 →Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 08 n/a Maintenance Electrican Black & Decker Pages 1 end 2 should be filed w itment of Health and Mental Hygien rtant: If item 27 is marked other ti jury or other traumatic event, ID 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Franklin Brown Ellen E. Dilworth ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Susan I. Babcock (Daughter) 9 Roosevelt Street Timonium, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Nov. 14, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If ony injury or 4 Donation 5 Other (Specify) Dulaney Valley Mem.Gar. 2006 Timonium, Maryland 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A 21. Signature of Funeral Service Licensee 2325 York Road Timonium, Maryland 21093 PM1. Enter the giscase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner signed by the attending physicien and do be detached for use as the burial-transit death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 VINO 3 Probably 4 Unknown 1 Tyes page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy performe certificate 2□ No 1 Yes 2 No 1 Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 No မှ 1 Yes 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation м 1 ☐ Yes 2 ☐ No 2 Accident hours after deat 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide To the Hospital 29a. Certifier t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 24 within 2 29d. Date signed (Month, Day, Year) License number 29b. Signature and title of certifier W 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) donic 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examinations to other traumatic event, the Medical Examinations to other provided at once.
A	Physician /Medical Examiner
Division of Vital Records, P.O. Box 68760,	o the Hospital or Attanding Physician: The law requires that the death certificate be executed ithin 24 hours after death.  of the Funeral Director: After this certificate has been signed by the attending physicien and on the funeral director, page 2 should be detached for use as the burial-transit

			For State Registrar	State of Marylan		artment of r rtificate of			a. No.	00700
er.		K.	Decedent's Name (First, Middle, Last	1)				2. Date of Death		3. Time of Death
	Physicia /Medic		BERBERA S	KTZBBBTH	Bosh	SIM		NOV	Day Year 2006	12.51 PM
	Examin	7 44	4a. Facility Name (If not institution, give				r Location of Death		4c. County of Dea	
***	.*		GOOD SAMARITAN				TIMORE		BALTIMO	
á	Funeral Director		311-20-6118	7. Age (In yrs.	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bin	thplace (State or Foreign ountry)
Т	bug w.		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation		,		10d. Inside City Limits
	fanyle aho ed at	ō	Orallo Gal		2	110				1 ☐ Yes 2 No
	the N	Directo	10e. Street and Number	C155	ALLEY	10f. Zip Code		10	g. Citizen of What Co	nuntry?
	death with the Maryland ms 23s or 28s-f show		ESSILAUREL DRIV	/3		211	3371		12.50	,
	ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.	S. 13.	Was Decedent of H	dispanic Origin? (Specan, Mexican, Puerto F	ify Yes or No-	14. Race - Ame	
2-003p	within 72 hours after death with the Marylan ene. than "natural", or Itema 23s or 28s-f show the Madical Examinations to notified at	þ	1★ Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes ②X No If Yes, Give Year or Dates:	i	1 Yes, specify Cub.		sican, etc.)	Black, White	te, etc.
5	72 ho	ted	15. Decedent's Edi (Specify only highest grad	ucation	16a. Deced	dent's Usual Occup	pation	g 1	6b. Kind of Business	/Industry
<u> </u>	within 72 ene. then "ne	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	during most of workin d)	9	1:	
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and	be fill	Be	17. Father's Name (First, Middle, Last)	9 110-0			18. Mother's Name		alden Sumame)	
Š	should nd Mer marks	2	KOGIRT II.	BOEHPIER	10b Mailie	a - Addraga (Ctana)	TRIVE		MOX	Zin Codol
<u> </u>	nit. Pages 1 and 2 should artment of Health and Mer ortent: If Item 27 is marke injury or other traumatic 8.		19a. Informant's Name/Relationship (7)	ype, Fility	190. Maill	IG Address (Sireer	and Number or Rural	House Number,	The Anna	1\30\1
a)	1 and Healt am 2		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of	14/15 1 EVII	ate 2	0c. Location - City or	Town, State
saitimore	Pages nent of int: If It iry or o		t⊠ Burial 2 ☐ Cremation 3 ☐ I	Removal from State	emetery, crer	natory or other pla	1	3, ~	1001:0:-	1 Clarke a
	permit. Page Department of Important: If any injury or once.	1	4 □ Donation 5 □ Other (Specify)  21. Signatur of during Service License	1- 1-	78 2/17T	2. Name and Addre	DEN 200		LINDER ICINE	ic I Haurara
n	Depa Impo any i		MAD ACE		21	AND FUN	527 CHO617	HIGH / HI	GON SERVIC	1000 Julion
£.			23a. Part1. Enter the disease, or comp	lications that caused the death			ng, such as cardiac or	respiratory arre	st,	Approximate
	Physician		shock, or heart failure. List only b	ANOXIC	ENIC	EPHALOI	PATIN			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a conseq		CPHALUI	MIHY			
	Examiner			RESPIRA		FAILU	RF			
4		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence				·		
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Š	e exe ien ar urial-t	Ë	resulting in death) Last	Due to (or as a consequence	uence of):					
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	entific ling p	Mec	IF FEMALE:							
X Q Q	death cer e attendir d for use	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1☐Live birth 2☐Feta	Ideath 3[	Ectopic pregnancy	у		23d. Date of de Month	livery Day Year
j.	that the death cer ed by the attendin detached for use	Physiclan/M	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	4☐ Pregnant at time of d 9☐ Unknown	eath 5L	Other (specify) _				•
1	that the ed by detac		Part II. Other significant conditions co	ontributing to death but not res	ulting in the u	nderlying cause giv	ren in Part I.	23e. Did tob	acco use contribute to	the cause of death?
g D	requires that een signed b hould be deta	d by	SQUAMOUS CELL	CANCER OF	MOUT	4		1 🗀 Ye:	s 2□No 3□Pi	robably 4 Unknown
Hecords,	w requires to been signer should be	Completed	DIABETES MEL	LITUS				24a. Was an	24h Were a	utopsy findings available
ě	et a co	E D	OTHOLIES TIL	-21100				autopsy	ed? prior to death?	completion of cause of
VIII all	(D) 1-4	Ö	25. Was case referred to medical				26. Place of Death	1 Yes 2		2 □ No
	Physician: this certific ral director,	0 B	examiner?	Hospital:	ER/Outpatier	t 3 DOA Ott	ner: 4 Nursing Hom			vity)
0		핕	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		ry at 2	8d. Describe hor		ony,
<u></u>	Attending r death. actor; Afte by the fune	atlo	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury		Yes 2 □No			
DIVISION	or Atten after deat Diractor; in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	eet, factory, office	2	8f. Location (Str. City or Town,	et and Number or Ri State)	ural Route Number,
5	talon rs aft	Cer					315		3444	
	To the Hospital or within 24 hours afte To the Funeral Dirt completely filled in I	edical	(Check only 2 Medical Exam	ysician: To the best of my kno iner: On the basis of examina	wiedge, deati tion and/or in	n occurred at the till vestigation, in my o	me, date and place, a opinion, death occurre	nd due to the ca d at the time, da	use(s) and manner as te and place, and due	s stated.  to the cause(s)
	To the within 2. To the complet	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens	se number	ەر.	d. Date signed (Mont	th Day Year!
	5 ½ 5 g		PO // 1	M.D.		1	-000		OV 09	
/	5	1 7	0 0		00-1				-	2006
4	1		30. Name and address of person who de ZUBAIR SHAIKH M.D., Co	completed cause of death (Item	HOSP	17AL 560	L LOCH RA	VEN BLVI	D. BALTIMA	RF MD21320
	Sta	te <sup>®</sup>	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ture				/ / / / / /	
	Registr		NOV 1 4 200	32 Registrar's Signa	1 Am	3464				

BARBARA

State of Maryland / Department of Health and Mental Hygiene [] [] [ 35904 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 09:43 M BUCKINGHAM 2006 NOVEMBER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner THE JOHNS HOSPITAL BALTIMORE . CITY HOPKINS N/A If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M 21XF Months Days Hours 13, 1934 Maryland **Director** 219-30-1910 Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Worle ! Pages 1 end 2 should be filed within 72 hours after deeth with the Maryla ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural; or iteme 23a or 28a-f ehov ury or othar traumatic evant, Ira McSical Examinar must be notified at 1 Yes 2 No Directo Maryland Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3716 Benson Ave. 21227 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No White altimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Social Security Ana.

18. Mother's Name (First, Middle, Maiden Suman 12 Analyst 17. Father's Name (First, Middle, Last) Be Katherine (unknown) Henry Nash 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jack D. Buckingham, Sr. / husband 3716 Benson Ave. Arbutus, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Depertment of H
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial Park 11-15-06 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 21. Signature of Funeral Service Licensee 2719 Hammonds Ferry Rd. Lansdowne, MD. 21227

Approximate Interval Between Onset and Death

23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death Immediate Cause (Finat disease or condition MYELOGENOUS LEUKEMIA Physician ACUTE 1 MONTH resulting in death) /Medical Due to (or as a consequence of): Examiner 2 WEEKS PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed ettending physicien and for use es the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day signed by the e 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed; 1 ☐ Yes 2 ☐ No this certificate 2 No 1 Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient ၉ 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Yes 2 No 2 Accident Diractor: 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral I Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Nouk RES-000 NOVEMBER 12, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 NORTH WOLFE STREET, BALTIMORE, MD 21205 NAIK RAKHI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 4 2006 Registrar The sale of

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryla		artment of H			giene Reg. No.2 0 0	6 35905
	Physici	an	1. Decedent's Name (First, Middle, Last)	George L.	Bents			2. Date of De.	Day Y	3. Time of Death
,	/Medic	al	4a. Facility Name (If not institution, give s		Jenes	4b. City, Town, or	r Location of Dea	NOVEMU	4c. County of	00 6 6 43 F.M.
	LAGIIIII		Balt more Wish	no ton Medica	Contor	Glen	Burgie	<u> </u>	Anne	Arundel
	Funeral Director		5. Social Security Number 6. Sex 217 18 2929	7. Age (in yrs	. last birthday) Yrs.	Months Days	If Under 24 Hr Hours Mi	n. 8. Date of Bird (Month, Da Oct. 20	th ly, Year) 1, 1922	9. Birthplace (State or Foreign Country) Maryland
5	70		Usual Residence of Decedent					000. 20	,, 1,11	
3	Aaryla f show	ŏ	10a. State 10b. County Maryland Anne Aru		ity, Town or Lo Millers					10d. Inside City Limits 1 ☐ Yes 2X☐ No
7	r 28a-	rect	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	nat Country?
_	23a o	ralD	341 Green Aspen			211			U.S.	
7	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evanting must be notified at 2008.	Funeral Directo	11. Marital Status 1 ☐ Never Married 2 △ Married	12. Was Decedent Ever in Armed Forces? 1 X Yes 2 No				(Specify Yes or No erto Rican, etc.)		- American Indian, White, etc.
215-0036	ural, o	Þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates: WW	<del>                                      </del>	1 ☐ Yes 216 No				White
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Maryland	I be filed ntal Hygi ed other event, I	Be	17. Father's Name (First, Middle, Last)  Lamber	rt W. Bentz				ame <i>(First, Middl</i> e, Len M. Co	, Maiden Sumame) nnors	)
aryla	should nd Men marke umatic	2	19a. Informant's Name/Relationship (Ty		19b. Mailir	ng Address (Street			er, City or Town, Si	tate, Zip Code)
	and 2 ealth a n 27 is		Steve Bents / Sor			Tarleton		-	Maryland	
ore	tges 1 t of H : If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F			sition (Name of natory or other place		Date		nie, Maryland
Baltimore,	permit. Page Department of Important: if any injury of		4 Donation 5 MOther (Specify).  21. Signature of Funeral Service License			. Name and Addre				vice, P.A.
ñ	Depa Impo any is			ramualy			nie High	way Balt	timore, M	aryland 21225
			23a. Part 1. Enter the disease, of compleshock, or heart failure. List only or Immediate Cause (Final	ications that caused the de- ne cause on each line.	ath. Do not ent	1	15		rrest,	Approximate Interval Between Onset and Death
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-		Completed by Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown		Ectopic pregnancy Other (specify)	<i>'</i>		Mont	h Day Year
P.0	requires that the der een signed by the a hould be detached h	Phy	Part II. Other significant conditions con	ntnbuting to death but not re	esulting in the µ	nderlying cause giv	en in Part I.	23e. Oid t	tobacco use contrib	oute to the cause of death?
rds,	w requires been sign should be	ed by	Septic Shoo	ik: Der	nenti	ai		10	Yes 2 No 3	B Probably 4 Unknown
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al B	Thate ate		QU	/				1 ☐ Yes	2 No 1	Yes 2 No
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0	ding Phys th. After this funeral di	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor		28d. Describe	how injury occurred	d
isio	Attanding r death.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Ptace of Injury - At	home, farm, str		Yes 2 □No			r or Rural Route Number,
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	To the Hospital or Attana within 24 hours after death To the Funeral Director: completely filled in by the	edical (	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my k iner: On the basis of exami and manner stated.	nowledge, deat nation and/or in	h occurred at the tir vestigation, in my o	me, date and pla opinion, death oc	ice, and due to the curred at the time,	cause(s) and mandate and place, an	ner as stated. nd due to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and mainer stated.		29c. Licens	se number		29d. Date signed	(Month, Day, Year)
			> Muasai	MO		000	3274	4	Novembe	VII 2006
10	1		30. Name and address of person who co		<sub>em 23a) (Type.</sub> lospita]		Glop P.	ırnio M-	ryland 21	/
	St	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sig		ANG 3	OTEH DI	лите, ма	ryrand 2	LUOI
	Regist	rar	JUS A I VAL	D This is a	STATE OF THE STATE	Day - March				

			For State Registrar	State of Mai	yland		rtment of I			-	giene Reg. No	711116	35906
	Physicia		1. Decedent's Name (First, Middle, Last	Mary Lou	ise	Bielas			"	Month No Vew	( Day	y Year	3. Time of Death
	/Medic Examin		4a. Facifity Name (If not institution, give			1201	4b. City, Town,	or Location		700 1011		. County of Dear	
	Funeral		5. Social Security Number 6. Se	TH OFF	OSP (In yrs. Ia	ast birthday)	If Under 1 Year Months Days		or 24 Hrs. 8	3. Date of Birt	th y, Year)	9. Bir	thplace (State or Foreign
	Director		216-36-6930 Usual Residence of Decedent	- 1 <sup>™</sup> 3 <sup>8</sup> - 1   67		Yrs.				(Month, Da Oct. 1	7,19	939 Ma	aryland
	ahow	2	10a. State 10b. County		10c. City	, Town or Loc	ation						10d. Inside City Limits 1 ☐ Yes 2 No
	r 28a-f	Director	Maryland Balt  10e. Street and Number	imore			10f. Zip Code	Es	sex		10g. Cit	tizen of What Co	
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36	be filed within 72 hours after death with the Maryland stal Hygiane. Id other than "natural", or items 23e or 28e-f ahow event, the Middred Extroiper front be notified at	by Funeral	11. Maritaf Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☑ Divorced	12, Was Decedent Ev Armed Forces? 1 ☐ Yes ♣☐No If Yes, Give Year or Dates:		If	/as Decedent of I Yes, specify Cub ☐ Yes 2 3 No	an, Mexica	an, Puerto Ri	ify Yes or No ican, etc.)	-	14. Race - Ame Black, Whit Specify: WI	
2-0(	72 hou		15. Decedent's Edu (Specify only highest grad	ucation de completed)		(Give I	ent's Usual Occu	during mo	ost of working	7	16b. K	ind of Business	/Industry
2121	d within giane.	Completed	Elementary/Secondary (0-12) 5 Years	College (1-4or 5+	)		<i>o not u</i> se retire sembly I	1	Worker	•	Gei	neral Mo	otors, Corp.
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, M. KII Irylanc	should be ind Mental is marked o	2	Harry Eugene Sco  19a. Informant's Name/Relationship (7)			19b. Mailin	g Address (Street	t and Num		-			Zip Code)
AS, Ma	end 2: eelth ai n 27 is ver treu		Mary J. King	(Daughte			ancis Gr	ceen		Lasc		Marylan	
Biclas timore, M	Peges 1 nent of Hi int: If iter iry or oth		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ I 4 □ Donation 5 □ Quer (Specify)		Ce	metery, crem	sition (Name of atory or other pla Cemeters		Da			ocation - City or	Town, State , Maryland
Dielas / M RA G Baltimore, Maryland 21215-0036	permit. Peges 1 end 2 should Department of Heelth and Men Important: If item 27 is marke eny injury or other treumatic ance.		21. Signature of Fundat Service Coens		- J	22. Du	Name and Address Ida-Ruck 22 Wise	ess of Fac Fune	ral Ho	me of	Dune	dalk, I	nc.
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the	he death							1. A. I. C.	Approximate Interval Between Onset and Death
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Division of Vital Records, P.O. Box	Attanding Physician: The law requires thet the deeth certific r deeth.  •ctor: After this certificate has been signed by the ettending p by the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. ff yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal	death 3	Ectopic pregnand Other (specify) _	ey				23d. Date of de Month	livery Day Year
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	To the Hospital o within 24 hours ef To the Funeral D completely filled in	Medical C	29a. Certifier (Check only one)  1. Certifying Phy 2 Medical Exam	ysician: To the best of iner: On the basis of e and manner state	xaminat	wledge, death ion and/or inv	occurred at the t estigation, in my	ime, date a opinion, de	and place, an	nd due to the d at the time,	cause(s date and	) and manner as d place, and due	s stated. e to the cause(s)
	To t To th	Σ	29b. Signature and title of certifier	arlel	4		29c. Licen	se number	100/1			ite signed (Mont	
	7		30. Name, and address of person who o	completed cause of dea	th (Item	23a) (Type, f	Print)	700	000	- (1	1000(	imbu 8,	2006
4			DR Lay Khin	9000 Fr	ank	Clin s	Square	DR	ive T	salti	Mor	e Md	21237
	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 4 2	32. Régistrar	's Signat	N A	no ve					,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Bronfein 5 2006 /Medical ee 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE RANDALLSTOWN NORTHWEST HOSPITAL CENTER If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign County KRAINE 7. Age (In yrs. last birthday) 8. Date of Birth 5. Social Security Number **Funeral** Days Months Hours 1 M 2 F 0171671919 87 216-42-8299 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28a-f sh notified 1 ☐ Yes 2 X No Director BALTIMORE OWINGS MILLS MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ral", or items 23a or Examiner must be r USA 21117 9113 THISTLEDOWN ROAD #197 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 💢 If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married WHITE 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: 2 3 Widowed 4 Divorced "natural". Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) is marked other than FOOD STORE MANAGER or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental I UNKNOWN permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. UNKNOWN BRONFEIN UNKNOWN 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9113 THISTLEDOWN ROAD #197 - OWINGS MILLS, MD 21117 ILENE BRONFEIN / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ☐Removal from State MIKRO KODESH BETH ISRAEL 11/12/06 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee Mott Cen 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Cerebrul bescules /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò page 2 should be 1 Yes 2 No 3 Probably 4. Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐No 24a, Was an autopsy 1∐ Yes 2 No or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: Other: 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No 1\_Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 ☐ Pending investigation 1. Natural 1 🗌 Yes 2 ∏No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled Hospital 🚧 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 029085 2000 NOU

State

31. Date filed (Month, Day, Year)

NOV 1

Registrar
DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4 2006

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 12 per fh 8861 11-14-06 vt.
State of Maryland / Department of Health and Mental Hygiene) 0.00 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Michael R. Christello, Sr. 6:45a 2006 10 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Bayview Medical Center Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Min. 1<u>⊠</u>M 2□F Months Days Hours 218-48-2540 58 1 - 20 - 1947Maryland Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a State Yes 2 No Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21224 1700 Kane Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

\*\*Modes 2 In No. 65-68
If Yes, Give Year or Dates. 1964-67 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Self-Employeed 12 Maintenance 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Sumame) Anna Marie Huber Plaza Christello 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Son 1700 Kane St., Baltimore, MD 21224 Michael Christello, Jr.-20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Bayview Crematory 1/-14-06 Baltimore, Md 22. Name and Address of Facility 2134 Willow Spring Rd. 21. Signature of Funeral Service Licensee BradleyAshton F.H.P.A. Balti. Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 months unknown Squamous cell caranoma Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were aulopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Deep venous thrombosis 24a. Was an autopsy performed 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 € ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Examiner The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, or Attending Physicien:

use as the burial-transit physicien and the ettending ۾ After this certificate has been signifuneral director, page 2 should be

**Physician** 

/Medical

Examiner

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Director

Funeral

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Completed

**Funeral** 

Director

r than "natural", or Items 23a or 28e-f ehow tre Medical Exercities must be notified at

other 1

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked other eny injury or other traumatic event 9068.

**Physician** /Medical

Examiner

Physician/Medicai

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Completed

Be

Certification: To

Medical

(Check only one)

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu To the Hospitei 0

State Registrar 29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1 S Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

D0035363

Baltmore

113/06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ION. Greene St. BVAMC

Sandra Marshella 31. Date filed (Month, Day, Year)

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Theodore Mottu Chandlee, Jr. 2006 LO NOU 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death N/A nion Memorial Hospital Baltimore If Under 1 Year if Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days 1**X**1M 2□ F Months 219-16-4172 82 January 26,1924 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits **Baltimore** 1 X Yes 2 No Maryland N/A10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 830 W. 40th St., Apt. 716 21211 United States 12. Was Decedent Ever in U.S. Armed Forces? 1XXYes 2□ NoKorea If Yes, Give Year or Dates:WW II Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) real estate mortgage banker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Theodore Mottu Chandlee Sr. Gleatina Green 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Chandlee/daughter 520 N St. NW, S-518 Washington, DC 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Greenmount crematory Nov. 13,2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc Raltimore, MD 21212 21. Signature of Funeral Service Licenses Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. shock, or heart fail Gastrointestinal day disease or condition resulting in death) Due to (or as a consequence of): 20 y ears rostate Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? unidosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an performed 26. Place of Death (Check only one)

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Funeral Director

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Completed

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Physician/Medical

Completed by

Be

Certification: To

Medical

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 ☐ Yes 2 ¥ No 27. Manner of Death 1 Natural

2 Accident

3 ☐ Suicide

29a Certifier

4 ☐ Homicide

5 Pending investigation 6 ☐ Could not be

determined

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

AT 243 8946

29c. License number

29d. Date signed (Month, Day, Year) 11-10-2006

10

State Registrar

etitia 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Union Memorial Huspital 32 Registrar's Signature

M.D.

			1- State of Manyland, Dena State of Manyland, Dena Per FH G861 11/14/06	rtment of Health and M tificate of Death	fental Hygier	2006 35910
A.	Physici /Medic		1. Decedent's Name (First, Middle, Last)  PHADON/A	ARTER	2. Date of Death Month	Day Year 3. Time of Death 3:30 P M
A	Examir	er	4a. Facility Name (If not institution, give street and number) BALTIMORE VA REHAB & EXTENDED CARE CENTER	4b. City, Town, or Location of Death  BALTIMORE		4c. County of Death
	Funeral Director		5. Social Security Number  220 54 7184 6. Sex 1 M 2 F 7. Age (In yrs. last birthday)  Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Birthplace (State or Foreign Country)  MD
	e Maryland la-f ahow	ctor	MD Baltimore handal	lstawn		10d. Inside City Limits 1 ☐ Yes 2 No
	ath with th	ral Director	10e. Street and Number  3949 McDonogh Road	10f. Zip Code 2//33	10g.	Citizen of What Country? U.S. H
900	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic avent, the Medical Exeminer must be notified at	by Funeral	1 Never Married 2 Married 12 Yes 2 Ne	/as Decedent of Hispanic Origin? (Sp. Yes, specify Cuban, Mexican, Puerto  ☐ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Plack
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	1 and 2 sho Health and Iom 27 is mother traum		Cheron N. Johnson / Daughter, 3949		Prondallsto	run MD 21133
altimore	Page nent o ant: # ary or		Lacounal 2 Cremation 3 Linemoval from State	fore of Comment III lo		Location - City or Town, State
Bal	permit. Pag Department Important: any injury once.		Varh C. Cm	Range Range	dailstain m	
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Finat disease or condition resulting in death)  a	r the mode of dying, such as cardiac o	or respiratory arrest,	Approximate Interval Between Onset and Death
50, <	Examiner sicien and burial-transit	l Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):			
.O. Box 68760	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and ral director, page 2 should be detached for use as the buriat-transit	Physician/Medical		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
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Divis	or A lifter Dira in by	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	,	City or Town, St	
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death (Check only one)  Medical Examiner: On the basis of examination and/or invand manner stated.	estigation in my opinion, death occurr	ed at the time date !	and place, and due to the secure(a)
	To vitt	2	29b. Signature and title of certifier  MO	29c. License number 056508	70 70	Date signed (Month, Day, Year)  ON. S, 2006  A0  21218
7	6		39.00 Lock Raven Blud	Baltimore,	MD SH	140
	Sta Regist		31. Date filed (Month, Day, Year) 32 Aegistrar's Signature NOV 1 4 2006	who -		

		•	For State Registrar	State of Maryla	nd / Depa <i>Cei</i>	artment of F rtificate of	lealth and N Death	Mental Hygien Reg. N		35911	
			1. Decedent's Name (First, Middle, La	st)				2. Date of Death Month D	ay Year	3. Time of Death	
	Physicia /Medic		FRANCE	5	CA	LOSBY		Novamber		6 2103 PM	
	Examin		4a. Facility Name (If not institution, giv			4b. City, Town, o	Location of Death	4	c. County of Dea	ith	
			JOHNS HOPKINS BA				BALTIN				
	Funeral			Sex 7. Age (In yrs. last b		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	r) 9. Bit	nthplace (State or Foreign ountry)	
	Director	-	Usual Residence of Decedent		Yrs.			30 Plember 2	4,1944	MD	
	/land		10a. State 10b. County	10c. 0	City, Town or Lo	cation				10d. Inside City Limits	
	Man	tor	MD		Balt	imore				1 Yes 2 □ No	
	or 28	lrec	10e. Street and Number			10f. Zip Code		10g. C	10g. Citizen of What Country?		
	23a	rai	6200 Shipview	Way		212	24		U.S. F	<del>}</del>	
	teme teme	Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H f Yes, specify Cubi	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi		
36	within 72 hours after deeth with the Maryland ene. than "natural", or iteme 23e or 28e-f ehow the M. cical Exeminer mout be notilled at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		1□Yes 2X No	Specify:		Specify:		
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yla	Menta Menta arked attc ev	0	Frank M. Crasba	1, Sr.				estar Kin			
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<b>Baltimore</b> ,			12 Burial 2 ☐ Cremation 3 ☐	Demoval from State	cemetery, crei	natory`or other plac	cθ)				
ξij	rt. Parturt		4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lice)	ý)	Nocolla	un Cline	ery 11.15	· 2006 ughn C. Gire	Nood law	mp server	
Bal	permit. Departminents imports eny injuite.		21. Signature of Funeral Service Lice	1200	8	728 liber	rty Rel 7	andallotau	· MD	11122	
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	Dhysisian		shock, or heart failure. List only Immediate Cause (Final			= /				Interval Between Onset and Death	
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7		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a none	equanea of):						
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Ö,	be executed icien and burial-transit		resulting in death) Last	Due to (or as a cons	equence of):					I .	
8760	cate be executed physicien and the burial-transit	dicai		d					·		
9	eath certific attending p for use as	Mec	IF FEMALE:	23c. If yes, outcome of preg	20.004		-				
Box	attenc for us	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fe	etal death 3	Ectopic pregnance Other (specify)	1		23d. Date of de Month	Day Year	
P.O.	The law requires that the death certificate ate been signed by the attending physoage 2 should be detached for use as the	Physician/Me	1 □ Yes 2 □ No 9 □ Unknown	9⊟ Unknown	Goath St	_ Cuter (specify) _					
	res thet I igned by be deta		Part II. Other significant conditions	contributing to death but not r	esulting in the u	nderlying cause giv	en in Part I.	23e. Did tobacco	o use contribute	to the cause of death?	
sp.	uires sign lid be	d by						1 🗆 Yes	2 □ No 3 □ F	Probably 4 Unknown	
S	w requir been si should	Completed						24a. Was an	24b. Were a	utopsy findings available	
Re	The lar	E C						autopsy performed	death?	completion of cause of s 2 No	
Vital Records,		0	25. Was case referred to medical				26. Place of Dea	th (Check only one)	10 10	-	
<b>\Sqr</b>	d S	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3□ DOA Oth	er: 4 Nursing H	ome 5 Residence	6 ☐Other (Sp	ecify)	
n of			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injui Wo	y at rk?	28d. Describe how in	jury occurred		
Sio	Mtendil death. ctor: Al y the fu	atic	2 Accident investigation				Yes 2 □ No				
Division	i or Att efter d Direct d in by t	Certification;	3 Suicide 6 Could not be determined		t home, farm, st <i>ecify)</i>	reet, factory, office		28f. Location (Street City or Town, Sta		Rural Route Number,	
	Hospitel or Attending 24 hours efter death. Funerel Director: After tely filled in by the fune		On One Was a State of Co.	business To the business of south			war data and along	and due to the course	/-\		
	Hos 24 ho Fun stely f	Medical		hysician: To the best of my k miner: On the basis of exam and manner stated.							
	To the Hospitel of within 24 hours of To the Funeral D completely filled i	Me	29b. Signature and title of certifier	A 1		29c. Licens	se number	29d. C	Date signed (Mor	nth, Day, Year)	
	F 5 F ō		* Katheni	ni Thom	ao	RE	5-000	NOV	EMBER	10,2006	
	1		30. Name and ddress of person who	completed cause of death (I	tem 23a) (Type,					ę	
	5		DR. KATHERI	NE THOMA	5 494	O EAST	ERN AL	VENUE BA	LIMOS	m) 4224	
3	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sk	nature	7				,	
	Regist	rar	NOV 1 4 2006	The Course As	ASSESSED AS						

			For State Registrar		State of	f Maryla	and / Dep <i>Ce</i>	artmei rtifica					giene () Rag. No.	06	35912
	Dhyeio	on	1. Decedent's Name (Firs	t, Middle, Las	it)				-			2. Date of De	ath Day	Year	3. Time of Death
	Physic /Medi		Helen I			-		T				NOVE	MBER	5 21	006 1575M
	Examir	ner	4a. Facility Name (If not in							Location of	of Death			nty of Deat	n
11/02/02	Funenci		Upper Che 5. Social Security Number				nter rs. last birthday	) If Unde	l Ai	If Under		8. Date of Bir	th		hplace (State or Foreign
120	Funeral Director	ŀ	215-30-5782	1	□ M 245%F	73	Yrs.	Months	Days	Hours	Min.	(Month, Da			cyland
=	P.		Usual Residence of Dece	dent			a								-
	arylar	<u>-</u>	278	County			City, Town or L	ocation							10d. Inside City Limits 1 ☐ Yes 2 🛣 No
٤	the Marylan 28a-f ahow notified at	Director	4	arford		Jo	oppa	104.7	p Code				10g. Citizen o	4 What Co	
10	th with the Maryla 23a or 28a-f ahor	ä	10e. Street and Number 552 Old Jo	nna Ro	had.				21085				USA	4 What Co	outiny:
-:	death w	Funerai	11. Marital Status	ppa 100	12. Was Dece	dent Ever in	U.S. 13.	Was Dece	dent of Hi	spanic Ori	gin? (Spe	cify Yes or No	- 14. R		encan Indian,
w	after de	Ē	1 Never Married 2	Married	Armed For	2 🔀 No			ecify Cuba 2 <mark>⊠</mark> No			Rican, etc.)		lack, White	e, etc.
	5-UU36 72 hours after death with the Maryland natural', or Itama 23a or 28a-f ahow aloal Examiliar must be notified at	d by	3 ☐ Widowed 4 ☐ [	pessoviced	If Yes, Giv Year or Da	ates:							Spec		White
	Z1Z15-UU36 ad within 72 hours aff giene. er than "natural", or the Medical Exercit	Completed		ecedent's Ed y highest gra	lucation de completed)		(Give	edent's Usi e kind of w DO NOT i	ork done o	urina mos	t of worki	ng	16b. Kind of	Business/	Industry
1	within ene.	d mg	Elementary/Secondary 12	(0-12)	College (1	-4or 5+)		rary		,			U.S.	Gover	nment
	other	BeC	17. Father's Name (First,	Middle, Last)				rary_	Tecil	18. Mothe	r's Name	(First, Middle			THICTIC
5	aryian should be nd Mental n marked o	To B	ROV W. A	vers						Dor	othy	L. T	racev_		
0	V 0 = =	0.3	19a. Informant's Name/R		•			•		and Numbe	or or Rura	/ Route Numb	er, City or Tow		Zip Code)
	Ce, IN 1 and 2 Health tam 27 tam 27		Donna L. H		/ Daug		142.			Road,		dwin, M			Taum State
0			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cre	mation 3 🗆		State	cemetery, cre	matory or	other plac				20c. Locatio		
00	ITIM It. Pa It. Pa It. Pa It. It. It. It. It. It.	1.7	4 Donation 5 0			1								ir, M	aryland
0	Baltimo permit. Page Department o Important: if any injury or		21. Signature of Funeral Service Licensee  22. Name and Address of Facility McComas Funeral Home, P.A.  1317 Cokesbury Road, Abingdon, Maryland 21009											and 21000	
2			23a. Part1. Enter the dis-											dryı	Approximate Interval Between
	, Physician		shock, or heart failu Immediate Cause (Final disease or condition				1 1/2	. 7	7						Onset and Death
	/Medical		resulting in death)		Due to (	or as a cons	equence of):	in /	nro	mse	575				10 days
35	Examiner		Sequentially list condition	is.	a. Mese Due to ( 5 Snu, Due to (	11 60	Duell	065	hruc	40	n				Zuechs
77	ait sit	ine	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	ate 4	A 15250		11								Lea
0	BOX b8 / b0, death certificate be executed e attending physician and of for use as the buriat-transit	Examiner	that initiated events resulting in death) Last		c. Sura i		adhe	101	J						yeors
~	8 / 50, ate be ex thysician	lical E			d										
) E	OX 68 certificat Iding phy Ise as th	led			_								- 11		
(1)	BOX lath cer attendin for use	Physician/Med	IF FEMALE: 23b. Was decedent preg- in the past 12 mopth		23c. If yes, out 1□Live b	come of predicts		□Ectopic	pregnancy					Date of del Month	livery Day Year
2	the all	/sici	1 Yes 2 No	(3:	4□Pregn 9□Unkno	ant at time o	death 5	Other (s	pecify)					no.un	buy tou
7	that the ded by the detached	P.	Part II. Other significant	conditions o	ontributing to de	eath but not	resulting in the	underlying	cause give	n in Part I		23e. Did t	obacco use co	ontribute to	the cause of death?
	HECOTGS, The law requires te hes been sign age 2 should be	Completed by	Chronic	renal	Faile	re,	rena	10	211	cone	er	10	Yes 2 No	3 🗌 Pr	robably 4 Unknown
56	aw rec	piete	Coronary	arter	y dise	use.	cetri	e C	hoille	ntion		24a. Was		o. Were at	utopsy findings available completion of cause of
3	The i	E										auto perfo	rmed3	death?	2 No
O:	r Vital ysician: T is certificet director, pa	Be (	25. Was case referred to examiner?			,			Lou		of Death	Check only	one/		
8:	Of \Physic this cral dire	ည	1 ☐ Yes 2 ☑ No				☐ ER/Outpatie			7 🗆 110		ne 5 Resi			cify)
	Jing F After funer	ion	_	Pending investigation		h, Day Year	28b. Time ( Injury	M	28c. Injury Work	rat ⟨? Yes 2		200. Describe	now injury occ	uried	
	DIVISION Of VITA to Attending Physician: effer death. Director: After this certific in by the funeral director,	Certification:		Could not be	28e. Place		t home, larm, s	treet, lacto				28f. Location (	Street and Nu	mber or Ri	ural Route Number,
i	P staric	Cert	4  Homicide		buildir	ng, etc. (Spe	эсіту)					City or To	wn, State)		
	A T J	edical (	29a. Certifier 1 (Check only 2 In one)	Certifying Ph Medical Exam	ysician: To the ninar: On the ba and mann	asis of exam	knowledge, dea ination and/or i	th occurre	d at the tim n, in my op	ie, date an pinion, dea	nd place, th occurr	and due to the ed at the time,	cause(s) and date and plac	manner as e, and due	s stated. to the cause(s)
	To the vithin 2 To the complet	M	29b. Signature and title o	certifier				2	c. License	number			29d. Date sig	ned (Mont	h, Day, Year)
	and a		194	MO				1	000	937	20		Voum 6	er, s	1, 2006
	6 V		30. Name and address of								J				
	- 01		Elie Fruiji, M. 31. Date filed (Month, Da			ecepece egistrar's Si			- 716	501 A	ar, m	1) 2101	4		
	Regist	ate rar	NOV 1	4 200	6	ips of	E Sign	ROSE S							

06-08460 Sallie Camps

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar Certificate		, 5	g No. 2006	3591
Physic Medical Exam		Decedent's Name (First, Middle, Last)	_	2. Date of Death Month November		3. Time of Death 0630 hrs
nd I diag		Sallie 4a. Facility Name (if not institution, give street and number)	Camps  4b. City, Town, or Location of De		7, 2006 4c. County of Death	0630 Hrs
)».		5743 Edmondson Avenue	Catonsville		Baltimore Cour	ity
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		Hrs. 8. Date of Birt	h(MM/DD/YYYY) 9. Birth Foreign	place (State or
Director			Yrs. World's Days Hours	02 2	27 11 Cour	ntry) NC
any		Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Lo	cation			Od. Inside City Limits
<b>*</b> .	'n	MD NA Baltimo	re			1 Yes 2X No
Maryland 28a-f sho d at once	Director	10e. Street and Number	10f Zip Code	10	g. Citizen of What Countr	y?
ith the M 23a or 2 notified		911 Leaden Hall Street #515	21230		U.S.A.	
eath wi	Funeral	1 Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - America White, etc.	n Indian, Black,
ifter de Il", or ner mu	by Fu	1 Yes 2 X No 3 X Widowed 4 Divorced or Dates 1 1 1	Yes 2 X No specify:		Specify: R1	ack
hours a	eted b	15. Decedent's Education (Specify only highest grade completed)  16a. Decedenting	dent's Usual Decupation (Give kind most of working life. DD NDT use		16b. Kind of Business/Inc	dustry
36 nin 72 s than "	plet	Elementary/Secondary (0-12) College (1-4 or 5+)	actory Worker	ctiredy	Maryland Cloth Com	
215-0036 be filed within 7 ntal Hygiene rked other than ent, the Medica	Comple	17. Father's Name (First, Middle, Last)	-	me (First, Middle, M		
1218 l be fill ental E rrked	Be	Tom Bigger	Ella	Bigger		
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Heath and Manhal Hygens I will the All and Mend of the rhan "natural", or items 23a or 28a-f she mit. If items 1's marked other than "natural", or items 23a or 28a-f she mit. If item I was the notified at once rother traunnatic event, the Medical Examiner must be notified at once	P P		ling Address (Street and Number of Clarks Lane			
ore, MC es I and 2 s of Health ar If item 27		20a. Method of Disposition 20b. Place of Disp	position (Name of cemetery,	Date Date	20c. Location - City or To	
MOFE  Pages I  ent of F  nt: If i		1 X Burial 2 Cremation 3 Removal from State crematory or 4 Popnation 5 Other Specify:		1/13/06	Baltimore	. МД
Baltimore, permit Pages I ar Department of Hee Important: If ite	1	4 Direct Specify.	Name and Address of Eacility arch F/H West			,
		236. Part I. Enter the disease, or complications that caused the death. Do not enter	300 Wabash Av	e, Balti	more, Md	21215
Physician /Medical		failure. List only one cause on each line				Approximate Interval Between Onset and Death
≒xaminer	1	Immediate Cause (Final disease or condition resulting in death)  a Right shoulder and claw Due to (or as a consequence of): at her	rosclerotic cardiovas	dicating hy scular disea	retensive ase	Deatri
	_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated				
nted d ansit		events resulting in death) Last  Due to (or as a consequence of):  d.				
760, cate be executed physician and ihe burial - transi	edical	TV. workings	Ba-f, perME, g863, 1/	/16/07 TT		
	ΣΙ	IF FEMALE: 23c. If yes, outcome of pregnancy	a 1, perms, good, 1/	10/0/ 11	23d Date of delivery	
Sox 687 leath certifi e attending for use as t	/sician/	past 12 months?	Fetal death 3Ectopic preg Dther (S <i>pecify</i> )	nancy	Month Day	/ Year
Ed the Em	Physi	1 Yes 2 No 9 V Unknown 9 Unknown				
ires that the signed by	by P	Part II. Other significant conditions contributing to death but not resulting in the Dementia, hyperthyroidism	e underlying cause given in Part I	23e. Did tob	acco use contribute to the	
ds, lequires	sted	Michiella, Hyperenyrondian		- 24a. Was ar		osy findings available
Records, The law require ficate has been si	Completed			autopsy perform	prior to con	pletion of cause of
		25. Was case referred to medical	26 Place of Death (Chec	1 Yes 2	No 1 Yes	2 No
Division of Vital I Hospital or Attending Physician: 24 hours after deaths, dier this certification: After this certificity filled in by the funeral director.	To Be	examıner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatie	Othor		esidence 6 🗸 Other: S	cene
Ing Pl	ä	27. Manner of Death  1 Natural 5 Deading (Month, Day, Year)  28b. Time of Month, Day, Year)	· · · · _ · ·	28d Describe ho	w injury occurred	
Division all or Attendins after death.  al Director: All Director All of the fu	catic	2 Accident Pending Investigation Fnd 11/7/2006 Fnd 6:2		unknown		
Divi	Certification:	3 Suicide 6 X Could not be determined (Specify) Nursing Home	reet, factory, office building, etc.	or Town, Sta	teet and Number or Rural te) 5743 Edmonds	Route Number, City on Ave.
		29a. Certifier (Check only) 1 Certifying Physician: To the best of my knowledge, death occ	curred at the time, date and place, a	partimore,	T.II.J	
To the within To the comple	Medical	one) 2 Medical Examiner; On the basis of examination and/or investige and manner stated.	gation, in my opinion, death occurred	d at the time, date an	nd place, and due to the c	ause(s)
	Σ	29b. Signature and title of certifier	29c. License number	j	29d. Date signed (Month)	Day, Year)
		20. Name and address of parens who completed across of dark (1).	O.C.M.E.		November 8, 2006	
		30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn	Street, Baltimore, MD 212	01		
		31. Date filed (Month, Day, Year) Registrar's Signature	4.			
Regis	-	NOV 1 4 2006		<del></del>		
Dinivin 1. Rev 1/2	UUT	ORIGIN	AL			

OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20b, c per fh 9861 11-16-06 vt. State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death DUPRFE Month Year **Physician** GNES 5:40 AM 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SE Bon HOSPITAL BALTI MORE TI COURS If Under 1 Year | If Under 24 Hrs. 8.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 7, 1948 2/1-50 - 24/7 Usual Residence of Decedent 1 ☐ M 2 🗷 F Yrs Director NORTH 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ehow Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Heatth and Mental Hygiene.
snt: If Item 27 is marked other then "natural", or Iteme 23a or 28a-f ehow ury or other traumatic event, the Medical Examinar must be notified at 1XYes 2 No Director 10e. Street and Number 10g. Citizen of What Country? USA. ON Funeral Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) THGRADE TOUSE KEEPER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 OWARD JLOVER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) )AUGHTER 20a. Method of Disposition 20c. Location - City or Town, State
Lansdowne permit. Pages
Department of t
Important: If Ite
eny injury or ot
once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ROWK SE FO ietics 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ⊠Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 1 Yes 2 No 1 Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

been signed by the attending physicien and should be detached for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, has After this certificate funeral director, pag After within 24 hours are.
To the Funeral Director: A the Hospital Tot

Baltimore, Maryland 21215-0036

State Registrar

Medical

31. Date filed (Month, Day, Year) 2006 :4

29b. Signature and title of certifier

SANDHU

W 940 Registrar's Signature

HYSICIAN

Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO



29c. License number

87.

BALTIMURE

29d. Date signed (Month, Day, Year)

mo 21223

DHMH 17 Rev 1/2001

Registrar

		1 - For State Registrar	State of M	larylar	-		t of H			•		ene 20	16	359	916
Dhusia	2	1. Decedent's Name (First, Middle, Las	it)							2. Date of Month	Death	Day	Year	3. Time	of Death
Physic /Medi		James William Du									8,	2006		1	4 P M
Exami	ner	4a. Facility Name (If not institution, give		)				Location of	Death			4c. Count			
		21 English Elm Co	ourt 7.A	ae (In vrs.	last birthday)		ONSV	ille	4 Hrs.	8. Date of	Birth	Balt:			or Foreign
Funeral Director		215-50-5164 Usuel Residence of Decedent	ex 7. A	53	Yrs.	Months Days Hours Min. 8. Date of Birth (Month, Day, May 20,				Day.	1953	9. Birthplace (State or Foreign Country) MD			
yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						-		10d. Inside	
e Mar	ctor	Maryland Baltimo	re		Catons	sville	2							1 🗌 Ye	s 2 No
or 28	Dire	10e. Street and Number				10f. Zip					10g. Citizen ol What Country?				
s 23s	ig.	21 English Elm Co		t Ever in H	6 12	Mac Dass		1228	in? (Cno	oitu Van as	No		USA	ican Indian	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any Injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Directo	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Yes 2 X	? ]No			Vas Decedent of Hispanic Origin? (Specify Yes or No- Yes, specify Cuban, Mexican, Puerto Rican, etc.)  ☐ Yes 2♥ No Specify:			NO-	14. Race - American Indian, Black, White, etc. Specify: White				
tural	edb	15. Decedent's Ed	Year or Dates:  ucation   16a. Decedent's Usual Occupation						1	6b. Kind of B	Business/I	ndustry			
n n n	Completed	(Specify only highest gra		5.4	(Give	kind of wo DO NOT u	nk done a	luring most	of workir	ng	'			,	
d will giene ar tha	ĕ	Elementary/Secondary (0-12)	4	3+)	Sale	s Exe	ecuti	ive			_   ]	Leonar	d Pa	per	
al Hy al Hy	Be	17. Father's Name (First, Middle, Last)										aiden Surnai	me)	_	
y and bould to Ment	2	James W. Dulaney Mary E								-					
12 sh n and r ls m		19a. Informant's Name/Relationship ( Kathleen Dulane				•						City or Town			) <b>)</b> 있
T and Health	-	20a. Method of Disposition	y, WILE	20b. F	_	A Company of the last				ate	nsville, Maryland 21228  20c. Location - City or Town, State				
ages nt of nt of		1 Durial 2 Cremation 3 □		9	Place of Disponentery, cres			- 1	1 /1 1	100			•		<b>(</b> D)
artme brteni Injury		4 □Donation 5 □ Other (Specify 21. Signature of Funeral Service Licer		St.	Micha							oplar	Spri	ns, N	
Per Per Per Per Per Per Per Per Per Per		VIM M	act on	0	Ņ	lacNal	ob Fi ceder	ss of Facility Ineral	. Hon	ne P.A	A. imor	re, Ma	rvl a	nd 212	78
		23a. Parl . Enter the disease, or com shick, or heart failure. List only	plications that cause	ed the deat									Lyla	Approxim Interval B	ate
Physician	10	Immediate Cause (Final disease or condition			GEAL	C	ANIC	SR					14	Onset aq	Death
/Medical	-	resulting in death)	a. Due to (or a		· · · · · · · · · · · · · · · · · · ·										Citio
Examiner	_	Sequentially list conditions,	b			_									
pe iis	ine	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause or injury													
ate be executed hysicien and he burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	s a consec	uence ol):										
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ficate g phys			a												
onding use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Testania a						23d. Da	ate ol deli	/ery	
death death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 4 Pregnant			∃Ectopic p ∃Other (sµ						M	onth	Day	Year
by the stacke	hys	9 Unknown	9□ Unknown												
w requires thet the death certifica seen signed by the attending phashould be delached for use as the	þ	Part II. Other significant conditions of	ontributing to death	but not res	sulting in the u	nderlying o	ause give	en in Part I.			id toba	2 No		the cause of bably 4	
w requir been si should	Completed									24a. W	las an	245	Were out	opsy finding	e available
he tay	E G									a	utopsy erform	ed3/	prior to c death?	ompletion of	cause of
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ysicie s cert direct	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpa	tient 2	] ER/Outpatier	nt 3 🗆 D0	OA Othe	00			,	/ nce 6 ⊟Oti	her (Spec	ifv)	
g Ph g		27. Manner of Death	28a. Date of In (Month, D	iury	28b. Time o		28c. Injury Work					v injury occu			
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ol or Atte after de Directe d in by th	Certification:	3 Suicide 6 Could not b 4 Homicide determined	200. Place of I	njury - At h etc. <i>(Speci</i>	ome, larm, sti fy)	reet, lactor	y, office		2	28I. Locatio City or	n (Stre Town,	et and Num State)	ber or Ru	ral Route Nu	m <i>ber</i> ,
DIVISION OF VIGAL NECOLAS, T.C. BOX OF ON The Hospitel or Attending Physician: The law requires thet the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phrompietely filled in by the funeral director, page 2 should be delached for use as it	edical C	29a. Certifier 1 Certifying Pt (Check only one)	nysician: To the best ninar: On the basis and manner:	of examina	owledge, deat ation and/or in	h occurred vestigation	at the tim	ne, date and pinion, death	place, a	and due to	the cau	use(s) and m te and place,	anner as and due	stated. to the cause	)(s)
To the within Fo the	Me	29b. Signature and title of certifier					c. License				29	d. Date signe	ed (Month	, Day, Year)	
		intely.	~ KD	•			05.	156	3		No.	Jamese	9.	2904	5
10		30. Name and address of person who	completed cause of	death (iter	m 23a) (Type,			`				JEMBER ACT. 20	` `		
12			Jenns Ho	FL-N	5 600	N <sub>e</sub>	RIH	Wor	Fr.	3377	<u> </u>	MCT. NO	39	TARYL	ans
St Regist	ate rar	31. Date liled (Month, Day, Year)	32. Regis	trar's Sign	ature	1	,								

DHMH 17 Rev 1/2001

ORIGINAL

		1 - For State Registrar	State of Mar			of Health and of Death		iene2 0 0 6	35917
Physicia ///		1. Decedent's Name (First, Middle, La Agnes C. Daws	•				2. Date of Deat Month	Day Year	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, giv	11 -1	101	4b. City, To	wn, or Location of Deat	h	4c. County of Deat	h
Funeral	H	5. Social Security Number 6.5		Lenter In yrs. last birthday	If Under 1		8. Date of Birth	15altir	norce (State or Foreign
Director		214-22-7027	1□M 20XF 79	Yrs.	Months D	Days Hours Min.	8. Date of Birth (Month, Day, July 14	1, 1927 Mari	ykand
faryland show		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town or L	ocation				10d. Inside City Limits
the Maryla 28a-f shor	ctor	Maryland Baltimo	re		Nottin	ıgham			1 ☐ Yes 2 🂢 No
with the M. ba or 28a-f	i Dire	10e. Street and Number 3826 E. Joppa 1	Road		10f. Zip Co	21236	1	Og. Citizen of What Co	untry?
r death w	ınera	11. Marital Status	12. Was Decedent Eve Armed Forces? 1 \( \text{Yes} \) 2 \( \text{X}\) No	er in U.S. 13.	Was Deceden	it of Hispanic Origin? (S Cuban, Mexican, Puer	Specify Yes or No-	14. Race - Ame	
d 21215-0036 d 21215-0036 filed within 72 hours after death with the Maryland thygiene. ther then "natural", or frems 23a or 28a-f show ont, the Mudical Examitter must be notified at	by Funeral Director	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣			Specify: (J)	ite
DES		15. Decedent's E (Specify only highest gra		16a. Dece	edent's Usual C	Occupation done during most of wo	rking	16b. Kind of Business/	
Mithin within then.	ompi	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOTUSO 1 memaken	done during most of wor retired) L		Own Home	
be filed wall Hygin of other went,	Be Completed	17. Father's Name (First, Middle, Last,					me (First, Middle, A		
arylan should be should be to marked	٥	John C. Braus  19a. Informant's Name/Relationship (	n, Sr.	19h Mail	ing Address (S	Marie  Treet and Number or Ri		City or Town State 2	(in Code)
- Clare			(daughter)			opa Rd., No			
		20a. Method of Disposition 1 🂢 Burial 2 □ Cremation 3 □	Juenioval nom State	20b. Place of Disponentery, cre				20c. Location - City or	
Baltimo Baltimo permit. Page Department of Important: if Important: if Important of		4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Lice				th Cem. 11/			
M Faria		Alitale	4	1		elair Rd.,			
Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Acite  Due to (or as a c	consequence of):	I. Hea	or of Dis	iease		Approximate Interval Between Onset and Death
58760 Crate be executed physicien and it the burial-transit		resulting in death) Last	Dy¶e tố (oras a c	onsequence of):					
Vision of Vital Records, P.O. Box 68760.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 [ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	⊒Ectopic pregr ⊒ Other <i>(specif</i>			23d. Date of deli	very Day Year
rds, P quires that n signed to	Completed by P	Part II Other significant conditions of	contributing to death but r	not resulting in the u	inderlying caus	se given in Part I.		acco use contribute to	the cause of death?
Records, e law requires has been sign pe 2 should be	plete	C.O.P.D.					24a. Was ar		topsy findings available ompletion of cause of
al Recorded to the coate his page							perform	ned? death?	2 No
Vita	To Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☑ No	Hospital:	2 PER/Outpatie	nt 3 DOA	Other	ath (Check only one	e) nce 6 □Other (Spec	(6.)
n Of ng Phy Mer thi	on: T	27. Manner of Death 1 ■Natural 5 □ Pending	28a. Date of Injury (Month, Day Y			Injury at Work?	28d. Describe ho		<i>"y</i> )
Division of Vital Records, to attending Physician: The law requires the death.  Director: Attenthis certificate has been signed in by the funeral director, page 2 should be control.	Certification;	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	e 290 Blace et leiur	- At home, farm, st	М	1 ☐ Yes 2 ☐ No	28f. Location (Str City or Town	eet and Number or Ru State)	ral Route Number,
\$ 5 E 9	Medicai Ce	29a. Certifier (Check only one)	nysician: To the best of miner: On the basis of example and manner stated	amination and/or in	th occurred at the	he time, date and place my opinion, death occu	, and due to the ca rred at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
To th withir To th comp	M	29b. Signature and title of certifier	1.			cense number		d. Date signed (Month	
12		30. Name and address of persults of	completed cause of door	h (Item 23a) (Tues	Print\	2003 3341		11/07/	W6
	,	Dr. Thomas Kri	Sarda 900	o Frank	Blin S	guare Dr	ve Bai	Himore M	10,21237
Stat Registra		31. Date filed (Month, Day, Year)	32. Abgistrar's	Signature	PART OF THE				

DHMH 17 Rev 1/2001

			1- State of Maryland / Department of Head State of Maryland / Department of Head Certificate of Department of Head State of Maryland / Department /	ooth	ien 2006 35918						
	G.		Decedent's Name (First, Middle, Last)	2. Date of Death	h 3. Time of Death						
	Physici /Medio		GEORGE MONTRAVILLE DAVENPORT, JR.	Novembe:	r 9. 2006 3:20 P M						
	Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Lo		4c. County of Death						
			BROADMEAD Cockeys		Baltimore County						
	Funeral		1 X M 2 F	Hours Min. 8. Date of Birth (Month, Day,	Year)  9. Birthplace (State or Foreign Country)						
	Director		417-01-1888 93 Yrs. Usual Residence of Decedent	June 24	, 1913 Alabama						
	/land		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits						
	Man	ţo	Maryland Baltimore County Parkton		1 ☐ Yes 2 No						
	th tha	Director	10e. Street and Number 10f. Zip Code	10	Og. Citizen of What Country?						
	23e c	ie D	2101 Mt. Carmel Road 2	1120	USA						
	tems er m	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hisps If Yes, specify Cuban, N	anic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.						
36	72 hours aftar death with the Maryland naturel', or Items 23e or 28a-1 show areal Examiner must be natified at	by F	1 Never Married 2 Married 1 1 Ves 2 No	Specify:	Specify: White						
21215-0036	72 hours naturel',	ed b	15. Decedent's Education 16a. Decedent's Usual Occupation	in la	16b. Kind of Business/Industry						
15		Completed	(Specify only highest grade completed) (Give kind of work done duri	ng most of working	Pharmaceutical						
212	d within giene. ir then "	Eo	Elementary/Secondary (0-12)  College (1-4or 5+)  5+  Division Sales in	Manager	Corporation						
pu	ba filed ntal Hygid ed other event,	Bec	17. Father's Name (First, Middle, Last) 18	B. Mother's Name (First, Middle, M	faiden Sumame)						
/lai	should by nd Menta r marked umatic ev	10 E	George Montraville Davenport, Sr.	Sallie	МсСоу						
Maryland	2 shc and Is ma			Number or Rural Route Number,	City or Town, State, Zip Code)						
	s 1 and 2 should if Health and Men item 27 Is marke other treumatic				ston, Maryland 21047						
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State		Oc. Location - City or Town, State						
ţ	t. Pa rtmen rtant: rjury	1			Baltimore, Maryland						
Bal	parmit. Page Department of Important: If eny injury or once.		21. Signatury of Burnal Service Grant Servic								
			Martin D. Lawson 6500 York Ro 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, s	oad, Baltimore,	Maryland 21212 Approximate						
			shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	don's cardiac or respiratory are.	Interval Between Onset and Death						
	Physician /Medical		disease or condition resulting in death)	I FAILUR	E						
П	Examiner		Due to (or as a consequence of):  ATRIAL FIBE	7111 ATION							
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	1011/101	V						
08-	cuted	Examiner	that initiated events C.	/							
0,	sician and burial-transit	Ex	resulting in death) Last Due to (**r as a consequence of):								
8760,	age of	dical	d								
9		a	IF FEMALE:		'						
Вох	death certifi e attending id for use as	lan/	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of delivery  Month Day Year						
o.	0 0 0	Physiclan/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown 9 ☐ Unknown								
<u>α</u>	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	n Part I. 23e. Did toba	acco use contribute to the cause of death?						
rds,	quires that n signed b	d by	Esophanol concer	1 ☐ Yes	2 100 3 Probably 4 Unknown						
Record	w requir	lete	Colon Concer	24a. Was an	24b. Were autopsy findings available						
Re	9 4 9	Completed	Direct to Concle	autopsy perform	prior to completion of cause of death?						
Vital		Ф	25. We case referred medical	1 ☐ Yes 2 3. Place of eath <i>Check on one</i>	ØNo 1□Yes 2□No						
>	di S	To B	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other.	4 Urursing Home 5 ☐ Residen							
n of			27. Manner of Death 1 Postural 5 Pending 28a. Date of Injury 28b. Time of Unjury at Work?	28d. Describe how	v injury occurred						
Sio	Attending r death. ector: After by the fune	catio	2 ☐ Accident investigation M 1 ☐ Yes	2 🗆 No							
Division	or Att	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)						
	urs a	Se									
	24 hc Fun Fun	edical	29a. Certifier  (Check only one)  2   Medical Examiner: On the basis of examination and/or investigation, in my opinion and manner stated.	nate and place, and due to the cau on, death occurred at the time, dat	use(s) and manner as stated. te and place, and due to the cause(s)						
	To the Hospitel or Attend within 24 hours after deatl To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier 29c. License nu	ımber 29	d. Date signed (Month, Day, Year)						
	->-0		Barbara Carpella D31	7392	11/9/2001/1						
	.6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	010	21030						
	12		BARBARA CARROLL,MD. 13801 VOI	RK RD., COCK	EYSVILLE, MD						
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature								
	Registr	ar	MOV 1 4 2006 Brown De April								

CAEORGE DAVENPORT 11/9/2006 3:20pm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $200\,$ 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Wember 6,2006 2025 Sharan Dorsey 4a. Facility Name (If not institution, give street and number 4c. County of Death GreneRal Hospital ti MURO Year If Under 24 Hrs. If I Inder 1 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Months Days 1□M 2**X**F 217.62.4308 Usual Residence of Decedent August 1, 1954 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore MD 10e. Street and Number 10g. Citizen of What Country? Was Decedent Ever in U.S. 13. V Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 No Yes, Give 1 ☐ Yes 2X No Specify Black Specify: 3 □ Widowed 4 □ Divorced Year or Dates: Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Nursing Health Care 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Sumame) Herbert J. Dorsey Kase Marie Braxten 19a. Informant's Name/Relationship (Type, Pint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P318 Liberty Rd Rondall steur mb 91244

Date 20c. Location - City or Town, State Kose marie Dorsey/ Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Vaughn C. Green funeral service 11.13.2006 L 21. Signature of Funeral Service Licenses 8728 liberty Rd 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. au Randoulstain mo 21133 Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence 5/08 Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

, or itama 23a or 28a-f ahow

Funeral Director

Completed by

Be

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: if item 27 is marked other than "natural; or itema 23s or 28s-f show any injury or other traumatic avant, the Madical Examinar must be notified at

Maryland 21215-0036

Baltimore,

use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, physician After this certification To the Funeral Director: All To the Funeral Director: All To the Funeral Director: All To the Funeral Director: All To the Funeral Director: All To the Funeral Director: All To the Funeral Director: All To the Funeral Director: All To the Funeral Director: All To the Funeral Director

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Medical Certif

examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death t DMatural 2 Accident

5 Pending 3 Suicide 4 | Homicide

29a. Certifier

29b. Signature and title of certifier

28a. Date of Injury (Month, Day Year) investigation

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number 46505

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 7/06

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of	person who completed	cause of death (Item
		0 0/
Josanh T	Manmoh	10 11 (% 1
JUNEAU 1	///////////////////////////////////////	11601701

2006

31. Date filed (Month, Day, Year) State Registrar NOV 1 4 M.D. 40 Malyand
32. Registrar's Signature

anorth.

23a) (Type, Print)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

amend item 23a per doc 8861 11-14-06 vt.
State of Maryland / Department of Health and Mental Hygiene 1 1 5

		1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of F	Tealth and I Death		iene2 () () 6	35920	
		1. Decedent's Name (First, Middle, Las	st)				2. Date of Death	h	3. Time of Death	
Physi /Med		Ruth 1	Minnie Dis	ney			November November	Day Year 12, 2006	2:30pm <sup>M</sup>	
Exam		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. County of Death		
		Long View Nursin				nchester		Carroll		
Funera		5. Social Security Number 6. S		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,	Year) 9. Birthp		
Directo	r	213-05-2603  Usual Residence of Decedent	- X 9	5 Yrs.			Aug. 25	5, 1911 N	ſĎ	
land ow		10a. State 10b. County		10c. City, Town or Li	ocation			10d. Inside City Limits		
Mary	ţ	MD Carrol	11		Westmins	ter			1 ☐ Yes 2X No	
r 28e	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Coun	try?	
th wit	a D	937 Bear Branch H	Road			21157		USA		
r dea	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of H	ispanic Origin? (S	pecify Yes or No-	14. Race - Americ Black, White,		
36 saffe	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐XNo If Yes, Give		1 Yes 2 No	Specify:	, , ,	Specify: Whi		
21215-0036  d within 72 hours after death with the Maryland glene. er then "naturel", or Items 23e or 28e-1 show it the Medical Examiner must be notifined at	0 0	15. Decedent's Ed	Year or Dates:	162 Dags	dost's Havel Ossus	ation	16b. Kind of Business/Industry			
115 in 72 an 'n	Completed	(Specify only highest gra	de completed)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of worth	king	6b. Kind of Business/ind	iustry	
212	E O	Elementary/Secondary (0-12)	College (1-4or 5+)		dministra			Clerical		
filed filed other	e C	17. Father's Name (First, Middle, Last)					ne (First, Middle, M			
/lar	ToB	Frank	(Unknown	)		Kath	erine (U	nknown)		
Maryland d 2 should be file th and Mental Hy ?7 is marked oth	Į.	19a. Informant's Name/Relationship (7	* * * * * * * * * * * * * * * * * * * *					City or Town, State, Zip		
and and and and and an artr		Mrs. Mary Lou Tac	kett (Niec			ch Road I		er, MD 2115	7	
Ore ges 1 r of H if ital		20a. Method of Disposition 1 ⚠ Burial 2 ☐ Cremation 3 ☐	Removal from State		matory or other plac			Oc. Location - City or To	•	
Baltimore, Dermit. Pages 1 ar Department of Hea mportant: If item sny injury or otha		`4 □Donation 5 □ Other (Specify	)					andallstown	<u> </u>	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at	21. Signature of Funeral Service Licensee  ATT FUNERAL HOME & CHAPEI Sykesville, MD 21784 (410)-7								195)	
ficate be executed Horizon and mineral substitution and mineral substitutions in the burial-transit energy.	1	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a of the b. Due to (or as a of the control of the	consequence of):	age	- Puln	mary ,	Disem	Interval Between Onset and Death	
.O. BOX ( the death certi y the attending	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliver Month	y Day Year	
S, P	y Pi	Part II. Other significant conditions co	ontributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute to the	e cause of death?	
cords w require been sig							1 ☐ Yes	2 ♣No 3 ☐ Proba	ibly 4 □Unknown	
4ecor e law requ has been pe 2 shouk	Completed						24a. Was an	24b. Were autop	sy findings available	
The I	E						autopsy performe	ed? death?	pletion of cause of	
Vital F iician: Th certilicate rector, pag	Be (	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one)			
of V Physic this ce al dire	To	1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatier		4 M Nursing Ho	ome 5 ☐ Residen	ice 6 □Other (Specify,		
On of Vita ding Physician: After this certific funeral director,	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	/ear) 28b. Time of Injury	Work		28d. Describe how	v injury occurred		
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Division of Vital Records, for Attanding Physician: The law requires to after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be	Certification:	4 Homicide determined	building, etc.	- At home, farm, str (Specify)	eet, factory, office		City or Town,	eet and Number or Rural State)	Route Number,	
Division of Vita with the Hospitel or Attanding Physician: within 24 hours after death.  To the Funarel Director: Attenthis certific completely filled in by the funeral director,	edical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medicel Exem	/sician: To the best of tiner: On the basis of each and manner state	kamination and/or in	n occurred at the time vestigation, in my op	e, date and place, pinion, death occur	and due to the cau red at the time, date	use(s) and manner as sta e and place, and due to	ited. the cause(s)	
To the within 2 To the complet	Me	29b. Signature and title of certifier	2	0.1	29c. License	number	290	d. Date signed (Month, D	ay, Year)	
1 2 5		16 Julm h	, Imil	Muti	777	7443	1	1/12/20	06	
10		30. Name and address of person who o	ompleted cause of dea	th (Item 23a) (Type,	Print)	NIL	-1	4- ^	-0	
10		John W Mus	alum a	e88 Poole	Kd1	MIN	instu	W1711	3/	
S	tate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	A					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per doc 9861 11-14-06 vt. State of Maryland Department of Health and Mental Hygiene. Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Day Month William Henry Davis Jr. November 6, 2006 6:30 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Seeds of Compassion Assisted Living Aberdeen Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ MM 2 □ F Months 417-07-7526 95 30, 1911 Alabama Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 ☐ No Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 140 Baltimore Street 21001 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ▼ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 ☐ N If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: 3√∑ Widowed 4 □ Divorced Specify: WWII Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineering Technician U. S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Henry Davis Sr. Gussie Alberta Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia O. Coleman/ Daughter 127 North Banna Avenue, Covina, California 91724 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial 11-13-06 Bel Air, Maryland 21. Sign ne Fune Service Licenses 22. Name and Address of Facility
McComas Funeral Home, P. A. 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Mychy Collyminy Due to (or as a consequence of). AMILY THOMICK Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Willowin Due to (or a a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only e) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 V 1951 hence 6X Other (Specify) iving assisted 1 Yes 2 No 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. after death.

Director: After this certifice in by the funeral director.

Box 68760

**Physician** 

/Medical

Examiner

Funeral

Director

"natural", or Items 23a or 28e-1 show

and Mental Hygiene. Is marked other than

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once.

**Physician** 

/Medical

Examiner

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attending physical for use as the b

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Examiner

Be Completed by Physician/Medical

Certification: To

the Medical Examiner must be notified at

Director

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Completed

Be

with the Maryland

72 hours after

Baltimore, Maryland 21215-0036

within 24 hours a To the Funeral C Medical completely 0 State

31. Date filed (Month, Day, Year) VOV 1

30. Name and address of

29b. Signature and title of certifier

4 2006

erson who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

HUD

Registrar

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			For State Registrar	State of Ma	•		rtment of F tificate of			gien <b>e</b> U Reg. No.	Ub	33922	
	Miss A	£ ,	Decedent's Name (First, Middle, La	st)	, , , , , , , , , , , , , , , , , , , ,				2. Date of Dea	ath	Voss	3. Time of Death	
3	Physici /Medic		Harry Reginald	Detamore					Novembe Novembe	er 9, 2	2006	2:32 a M	
	Examin		4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, o	r Location of Death		4c. Cour	nty of Death		
	<sup>1</sup> a ×	<b>*</b>	502 Kenmore Ave				Bel A				Harfo		
	Funeral Director		212-32-2195	ex 7. Age	73	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day July 6			nlace (State or Foreign ntry) rland	
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Towr	or Loc	ation				1	0d. Inside City Limits	
	Maryli	tor	Maryland Harfor	rd	Bel A						1. Yes 2 □ No		
	or 28s	Director	10e. Street and Number				10f. Zip Code			10g. Citizen o	of What Cour	ntry?	
	23a c	rai	502 Kenmore Ave.				210			US.			
Maryland 21215-0036	be filed within 72 hours after deeth with the Maryland tal Hygiene of other then "natural", or iteme 23e or 28e-f ehow event. The Medical Examiner man be multipled at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 ☒N If Yes, Give Year or Dates:			as Decedent of H Yes, specify Cuba ☐ Yes 2  No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	В	lace - Americ Black, White, c <i>ify:</i> Whi	etc.	
5-0	72 ho	eted	15. Decedent's E (Specify only highest gra		16a.	Decede (Give k	ent's Usual Occup and of work done	pation during most of world)	king	16b. Kind of	Business/Ind	dustry	
121	within ene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	) Ge			<sup>ர)</sup> intendent		Con	struct	ion	
d 2	filed Hygid other		17. Father's Name (First, Middle, Last,	)			ar bapor	18. Mother's Nam					
an	Mental Mental arked o	To Be	Reginald Henry	Detamore				Marga	ret El	izabetl	h Rowe	!	
ary	permit. Pages 1 and 2 should be Department of Health and Mental Important: if item 27 is marked tent jury or other treumatic evonce.	7,	19a. Informant's Name/Relationship (					and Number or Rui				Code)	
			Vicki L. Brinkmar	- Daughte				Road, Per	The second second				
Baltimore,			20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specif		cemeter	p Se		orp. 11-1	.0-06		n-City or To n, Mar		
Balt	permit. Depart Import eny in		21. Signature of Funeral Service Lice			13		sbury Roa		gdon, I		P.A. 009	
3			23a. Part1. Enter the disease, or conschools, or heart failure. List only	plications that caused one cause on each lin	the death. Do n e.	not ente	r the mode of dyir	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between	
Po.	Physician		Immediate Cause (Final disease or condition	a Hy	poxic	2					The state of the s	Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a	consequence	of):						1475	
	***	20	Sequentially list conditions,	b. Due to (or as a	consequence of	of						0 413	
		Examiner	Sequentially list conditions, taily, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events										
o,	icate be executed physicien and s the burial-transit												
68760,	ate be hysici the bu	edicai											
	entific ding p												
P.O. Box	The law requires that the death centificate be executed tie hes been signed by the attending physicien and tage 2 should be detached for use as the burial-transit	by Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	Fetal death		Ectopic pregnancy Other (specify)	/			Date of delive Month	Day Year	
	s that ned b e deta	y Pt	Part II. Other significant conditions	contributing to death bu	t not resulting in	the und	derlying cause giv	en in Part I.	23e. Did to	bacco use co	ontribute to th	ne cause of death?	
rds	w require: been sig should b	ed b	CHF						1 <b>⊠</b> Y	es 2□No	3 Prob	ably 4 ∐Unknown	
Division of Vital Records,	The law re ate hes bee page 2 sho	Completed							24a. Was a autop perfor	med?	b. Were autop prior to con death? 1 \( \sum Yes	psy findings available appletion of cause of	
ital		BeC	25. Was case referred to medical examiner?					26. Place of Deal		-			
> =	Physicien: rthis certific ral director,	To	1 ☐ Yes 2 🕱 No		nt 2□ER/Out	tpatient		4   Norsing Fi	ome 5 Resid			1)	
o uc	ling P	ion:	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	<i>Year)</i> 28b. T	ime of njury	28c. Injur Wor	'k?	28d. Describe h	ow injury occ	urred		
isic	Attending r death. actor: After by the fune	icat	2 Accident investigatio 3 Suicide 6 Could not b	e 29a Place of Injur	ry - At home, far	rm stre		Yes 2 □No	28f. Location (S	Street and Nur	mber or Rura	I Route Number	
Σ	after after Direct of in by	Certification:	4 Homicide determined	building, etc	(Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	st, ractory, ornoc		City or Tow	m, State)			
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: Atter this completely filled in by the funeral directors.	edical C		nysician: To the best on the basis of and manner state	examination and								
	To the within To the comple	Me	29b. Signature and title of certifier	1	1/2 m. 3		29c. Licens		4	29d. Date sign			
	4		N. R. Har	apanaha	~ 712	*	145	680		NOV	9, 2	.006	
1	{		30. Name and address of person who Neclakanh R	completed cause of de Harapan	ath (Item 23a) ( ahalli f	Type, P	rint)#207	602 Se	Air M	wood ) 210	Road		
	Sta Registr	-	31. Date filed (Month, Day, Year)  NOV 1 4 200	6 Registra	r's Signature	par	E)						

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.
AHEND TIPHES, per INF., G863, 1/11/07, WS
State of Maryland / Department of Health and Mental Hygiene 0 6 35923 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dean 8,2006 Month 3:09 PM Gene November 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Conter Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Byth (Month Day, Year) Days Hours 12℃ M 2□ F Yrs 227-48-5510 68 Oct. -7,1938 Virginia Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Eastpoint Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 1046 Old North Point Road 21224 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2/OkNo Specify: Specify: 3 ☐ Widowed 4 (又Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tree Trimmer/Owner Tree Maintenance 6 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) General Roller Dean Mae Crawford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Zoe Camalier (Daughter) 1807 Walnut Ave. Dundalk, Marvland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ← Removal from State Dean Mountain Cemetery 11/13/2006 Elkton, Virginia → Donation 5 Other (Specify) 21. Signaline of Funeral Service Linense 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Marvland 21222 23a. Part. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between

**Physician** /Medical Examiner

other

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Department of Important: If any Injury or sonce.

**Physician** 

/Medical

Director

Completed by Funeral

To Be

Examiner

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant of Heatth and Mental Hygiene. ant: If Item 27 Ie marked other then "naturel", or Iteme 23a or 28a-f show

Baltimore, Maryland 21215-0036

27 is marked other then "naturel", or Iteme 23a or 28a-f show treumatic event, the Modinal Examinar must be notified at

Medical Certification: To Be Completed by Physician/Medical Examiner burial-transit use as the To the France after death.

To the Funeral Director: Alt

or Attending Physician: The law requires that the death certificate be executed

Hospital

this funeral

Division of Vital Records, P.O. Box 68760,

Immediate Cause (Final						Onset and Death
disease or condition resulting in death)	a. Preumoni	4				2 Weeks
resulting in death)	Due to (or as a consequent	ce of):				
A CONTRACTOR OF THE PARTY OF TH						
Sequentially list conditions, cause. Enter Underlying	Due to (or as a consecuence	an off):				
cause. Enter Underlying Cause (Disease or injury		,				
that initiated events resulting in death) Last	c					
resulting in death) cast	Due to (or as a consequent	ee of):				
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IF FEMALE:	220 If you system of account					
23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea	th 3□Ectopic	pregnancy	1	23d. Date of de	,
1 Yes 2 No	4☐Pregnant at time of death				Month	Day Year
9 Unknown	9□ Unknown					
Part II. Other significant conditions of	ontributing to death but not resulting	g in the underlyin	g cause given in Part I.	23e. Did tobacco	use contribute to	o the cause of death?
	-	, , , , , , , , , , , , , , , , , , , ,	•			/
				1 Yes	2 No 3 P	robably 4 Dinknown
				24a. Was an	24b. Were at	utopsy findings available
				autopsy performed?	prior to	completion of cause of
Water Committee of the				1 ☐ Yes 2/2/N		3 2 □ No
25. Was case referred to medical examiner?			26. Place of De	ath Check only one		
1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ☐ ER/	Outpatient 3	DOA Other: 4 Nursing H	lome 5 Residence	6 □Other (Spe	acity)
27. Manner of Death	28a. Date of Injury 28b	. Time of	28c. Injury at	28d. Describe how inj	nv occurred	Cny/
1 ⊠Natural 5 ☐ Pending	(Month, Day Year)	Injury	Work? 1 ☐ Yes 2 ☐ No		.,	
2 Accident investigation 3 Suicide 6 Could not be						
4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, lact	ory, office	28t. Location (Street a City or Town, Sta	nd Number or Ri	ural Route Number,
	g, etc. (epselly)			ony or rount, old	9	
29a. Certifier 1P Certifying Ph	ysician: To the best of my knowled	Ide death occurr	ed at the time, date and place	and due to the cause/	c) and manner or	a stated
(Check only 2 Medical Exam	ner: On the basis of examination	and/or investigati	on, in my opinion, death occu	urred at the time, date ar	nd place, and due	o to the cause(s)
	and manner stated.					
29b. Signature and title of certifier			29c. License number		ate signed (Mont	
1 000	all		RES -000	No	vember	-08,2006
				1 /		,

State Registrar

Mayy Chahla 31. Date filed (Month, Day, Year) -

32. Raistrar's Signature

4940 EasTern

NOV 1 2 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [ ] [ ] 1 - For State Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 3. Time of Death Year **Physician** Month November /Medical 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RUXTON NURSING HOME

5. Social Security Number 6. Sex 1 KESVILLE KESVILL TIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. Last birthday) Days 219-10-108 1 ☐ M 2 😿 F Yrs Director Usual Residence of Decedent deeth with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exara an inust by notified at 1 Yes 2 No Directo MARVLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deel Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or income any injury or other traumatic even. Was Decedent Ever in U.S Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No tf Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 9 TH GRADE College (1-4or 5+) ENGINEER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 HRTHUR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MABEL JOHNSON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City 1. Burial 2 ☐ Cremation 3 ☐ Removat from State ' 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tmmediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Wither /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the attending physicien and hed for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown 9 Unknown certificate has been signed by irector, page 2 should be detact Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 223 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death e Hospital or Attending Pl 24 hours after death. • Funeral Director: After the Certification; 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗍 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 737573 November 13, 2001 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

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Main

25 gistrar's Signature

115415

2006

31. Date filed (Month, Day, Year)

			1 – For State Registrar	State of Maryland		nt of Health and M te of Death		2000	35925
2	Physic	an	1. Decedent's Name (First, Middle, Las	0	- 11		2. Date of Death Month	Day Year	3. Time of Death
A	/Medi	al	<u>Shares</u>	T(	ulton	7	NOV	8 2006	
a valent	Examir Funeral Director	er	4a. Facility Name (If not institution, give Since Hospite)  5. Social Security Number  219-90-2301	e of Beltim	ore Ba	Town, or Location of Death  Chimore  T Year If Under 24 Hrs.  Days Hours Min.	8. Date of Birth (Month, Day, Ye O'Z 12	9. Birth	nplace (State or Foreign
	D		Usuel Residence of Decedent	90			02 12	1110	NCY
	the Maryland r 28a-f ehow	Director	10a. State 10b. County	B	Town or Location  Il timo				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	uth with the 23a or 28a ust be notifi	Dire	10e. Street and Number Re	vedere Ave	10f. Zip	Code	10g.	Citizen of What Co	untry?
	ler death	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Dece	dent of Hispanic Origin? (Spe cify Cuban, Mexican, Puerto I	cify Yes or No-	14. Race - Amer	
5-0036	rel', or	þ	1 Never Married 2 Marned 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		2 No Specify:	rican, etc.)	Specify:	slack.
215-(	hin 72 hours in "naturel", Medical Ex	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	16a. Decedent's Usu (Give kind of wo life. DO NOT u	ork done during most of workir	166	b. Kind of Business/I	ndustry
21	filed withir Hygiene.	Com	17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Die	Sabled 18, Mpther's Name	(First Middle Mair	den Sumamal	
Maryland	2 should be land Mentail la marked o	To Be	Michael L. t	ulton		Carolo	and	19/let	<u> </u>
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altimore	e = 5		20a. Method of Disposition  1	Tomovar irom otate	netery, grematory or of the leaves of Disposition (National National me of other place)		Location - City or 1	rown, State	
Balti	permit. Page Department o Importent: If any injury or once.		21. Signature of Fundial Service-Ligen	M. 20		d Address of Factor Reg	ne Fune	ral Sex	vices
	f 1 3		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the death.	Do not enter the mod	L. Derty Ko., K de of dying, such as cardiac or	respiratory arrest,	rown, Me	Approximate
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Lespiratory	, toilu	re		97.4	Interval Between Onset and Death
被	Examiner		Sequentially list conditions	Due to (or as a consequence b. PCP prece	nce of): emon's				20 days
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events	Due to (or as a consequent ATDS	nce of):				inknown
8760,	cate be executed physicien and the burial-transit	dical Exa	resulting in death) Last	Due to (or as a consequent	nce of):				_
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o,	ss that gned b	y P	Part II. Dther significant conditions co		ng in the undertying c	ause given in Part I.	23e. Did tobacc	co use contribute lo	the cause of death?
Records,	w require been signal	eted	Acute renal of	coilure			1 🗆 Yes	2□No 3□Pro	bebly 4 Dunknown
l Rec	The law ate has pege 2 s	Completed by					24a. Was an autopsy performed	? prior to ex	opsy findings available ompletion of cause of
Vita	certific	Be	25. Was case referred to medical examiner?	Hospital:		26. Place of Death	(Check only one)		
o	y Phys ar this aral dir	2	27. Manner of Death	1 Impatient 2 LEH	VOutpatient 3 DC		e 5 Residence	6 ☐Other (Speci	fy)
Division of Vital	tending eath. tor: Afte the fun	catlor	1 Vatural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		М	1 ☐ Yes 2 ☐ No		, a.y 00001100	
Divi	al or At s after d il Direct id in by	Certification:	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	ə, farm, street, factory	, office 2	3f. Location (Street City or Town, St	and Number or Run ate)	al Route Number,
	To the hospital of Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.4	Medical	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death occurred and/or investigation,	at the time, date and place, ar , in my opinion, death occurre	nd due to the cause d at the time, date a	e(s) and manner as s and place, and due t	stated. o the cause(s)
$\mathcal{Y}_{  }$	vithin To th compl	Me	29b. Signature and title of certifier			. License number		Date signed (Month,	
	1		Olge Szal		R	ES 000	N	00, 8, 20	006
	9		30. Name and address of person who c	ompleted Guse of death (Item 23	Sa) (Type, Print)	ES 000 ai Hospita	l of	Baltin	ore
100 jag	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	9		- U		
DHM	Registr		NOV 1 4 20	06 Herry B		9			
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sharese Fulton

Potient known as

			1 - For State Registrar	State of Marylan	id / Depa		Health and I	Mental Hyg	giene				
	Physic	ian	1. Decedent's Name (First, Middle, Lass	•				2. Date of Dea Month	th Day Yea	3. Time of Death			
	/Medi		Assunta T. ]  4a. Fecility Name (If not institution, give			4h Cihi Tour	or Location of Death	11	8 200				
	Exami	ner	13 E. Overlea				altimore		4c. County of D				
	Funeral		Social Security Number 6. Se	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.		9. E	Itimore  Birthplace (State or Foreign Country)			
п	Director		004-03-4077	□M 2 <b>X</b> ) F	95 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 10/30	/1911	Maine			
I	and *		Usual Residence of Decedent  10a. State 10b. County	10c Cit	y, Town or Lo	ncation				10d. Inside City Limits			
	Manyl f eho	ō	MD Baltir			imore				1 ☐ Yes <b>X</b> ☐No			
	r 28a	rec	10e. Street and Number			10f. Zip Code		1 1	0g. Citizen of What				
	72 hours after death with the Maryland "naturel", or Items 23s or 28s-f show edical Exeminar must be notified at	Funeral Director	13 E. Overlea	Ave.		212	206		USA	•			
	ems er m	Iner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of H	dispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	14. Race - Ar Black, W	merican Indian,			
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married  3CWidowed 4 ☐ Divorced	1 ☐ Yes 2 <b>X</b> No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:	,		White			
21215-0036	hour	ed b	15. Decedent's Edu	16a Dece	dent's Usual Occup	ation							
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212	be filed within tal Hygiene. d other than "	Completed	Elementary/Secondary (0-12)		Groce Stor	e 1							
nd	be filed tal Hygi of other	Be	17. Father's Name (First, Middle, Last)  Fabio Ciccone  18. Mother's Name (First Theres										
yla	Meni Meni Marke Marke	ို							petroAn				
Maryland	12 sh h and 7 is rr rreurr		19a. Informant's Name/Relationship (T)  Janice Knowles						City or Town, State				
	ges 1 and 2 should it of Health and Men it Item 27 is marks or other treumatic		20a. Method of Disposition		_	sition (Name of			ngdon, 1				
Baltimore,			1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State Ne	emetery, cren W Cal	natory`or other plac	Nove	mber	South Po	ortland,			
Ħ	permit. Pa Departmer Importent eny injury		21. Signature of Funeral Service Licens		emete	LY . Name and Addre	ss of Facility	2006	Maine				
B	Depa Impo eny i		15/10.1	Sulle	E	yans Fu	neral C tion Se	hapel	Parkvil	Harford Rd. le, MD21234			
68760,	be executed by sicion and building in a burial-transit	cal Examiner	25 Party Enter the disease, or complishook, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence)  Oue to (or as a consequence)  Oue to (or as a consequence)	uence of):  Figure of):		ALD EASE			Approximate Interval Between Onset and Death  WWTH			
. Box	death certifica e attending ph d for use as th	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1	death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	lelivery Day Year			
	aquires the		Part II. Other significant conditions con		ontribute to the cause of death?  3 Probably 4 Unknown								
Division of Vital Records,	Physicien: The law requires that the this certificate has been signed by the didicator, page 2 should be delached.	Completed						24a. Was ar autops perform 1 Yes 2	ned? prior to	autopsy findings available completion of cause of			
<u> </u>	icien certifi rector	Be	25. Was case referred to medical examiner?	lospital:		046		h (Check only one	9)				
ō	Phys r this ral dii	.T	1 Yes 2 No	1 Inpatient 2 2	ER/Outpatient 28b. Time of		4   Nursing no	me 5 Reside 28d. Describe ho	nce 6 Other (Sp	pecify)			
o	Attending in death.	F	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Injun Worl	k? Yes 2 □ No	20d. Describe 110	willigary occurred				
Divis	Hospitel or Attenc 24 hours after death Funerel Director: tely filled in by the i	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (Str City or Town	Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	edical	one)	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the tin estigation, in my o	ne, date and place, pinion, death occurr	and due to the ca red at the time, da	use(s) and manner a	as stated. ue to the cause(s)			
-	With To 1	Σ	29b. Signature and title of certifier			29c. License		29	d. Date signed (Mor	nth, Day, Year)			
			1 /Ve w	)		,	7945	^	vov 9 7	Log 6			
1	Y		30. Name and address of person who co	empleted cause of death (Item	23a) (Type, F		. 2	,					
1		10	31. Date filed (Month, Day, Year)	32. Registrar's Signat	UT CE	A ARLY	e tuw	1000	ing u	104			
	Sta			C Josephan G Digital	80 A.	2000 2							

DHMH 17 Rev 1/2001

06-08399

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Vincent Felix 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day November 5, 2006 2348 hrs Medical Examine Felix Vincent 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** Johns Hopkins Bayview Medical Center 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number Age (In yrs. last birthday) **Funeral** Foreign Months Days Hours Min Director Country)Maryland 220-66-0775 July 17,1955 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location III, 10a State 1 Yes 2 x No 28a-f show Dundalk Maryland Baltimore after death with the Maryland Director 10g Citizen of What Country 10e. Street and Number 10f. Zip Code must be notified at United States Apt. D 21222 or 2617 Yorkway items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, Armed Forces' White etc. 1 Never Married 2 Married Yes White Yes 2 X No specify: f Yes, Give Year Specify: Divorced Widowed 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry and 2 should be filed within 72 hours Completed Automobile th and Mental Hygiene
n 27 is marked other than "n
tumatic event, the Medical E College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 Maintenance Automobile Mechanic 11 Years 17 Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Grace Rager Lester Felix, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8810 Littlewood Road Towson, Maryland Mr. Larry Felix (Brother) nt of Health a nt: If item 27 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date crematory or other place) Burial 2 X Cremation 3 Removal from State Pages 1 tant: 11/10/2006 Towson, Maryland Hilltop Service Corp. Donation 5 Other Specify permit
Departm
Importa 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licensee 7922 Wise Ave. Dundalk, Maryland Approximate Interval Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and lure. List only one cause on each line /Medical Death a Cocaine intoxication complicating atherescleratic cardiovascular dis-Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical XUNPENDED AMENDED #23a,27,28a-f,perME,g861,11/15/06 TT ending physician use as the burial Box 68760. 23d Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Month Live birth Fetal death Day past 12 months Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I \$ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed' death? certificate page ✓ Yes 2 1 🗸 Yes 26. Place of Death (Check only one) 25. Was case referred to medical or Attending Physician: Be Other<sub>4</sub> examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1 🗸 Yes No 28a Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification Natural 1 Yes 2 No 5 Pending death. Fnd 11/5/2006 Funeral Director: stely filled in by the Fnd 11:17 pm unknown Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2617 York Way 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 X Could not be Suicide or Town, State)
Dundalk, MD determined (Specify) found in residence Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29d Date signed (Month, Day, Year) 29c License number 29b. Signature and title of certifie OCME November 6, 2006 30. Name and address of person who completed cause of death (Item 23a)

State Registra

DHMH 17 Rev 1/2001

OCMF 2006

Carol Allan, MD

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

2006

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

Han	s George	Gull		- For State	tate	of Maryla						Ment	al Hy	giene					
	Physi	rian		Registrar Certificate of Death Reg. No 201									0	3 Time of Death 2					
Med	dical Exa		-	Hans G. Gul										Month October	Dav	06 Year		1720 hrs	
P -				4a Facility Name (if not institut	on, give	e street and nu	mber)		41	Bet.	Town, or L hesda esday	ocation o	f Death		c. County of				
	Funera	al	7	5. Social Security Number	6. Se		7. Age (In	yrs last	birthday)	If Und	der 1 Year	If Under	r 24Hrs.	8. Date of E				hplace (State or Foreign	
	Directo		1	466-31-0068	ıX	M 2 F		6	57 Yrs.	Mont	hs Days	Hours	Min	Jan	9. 1	939	-	<sup>intry)</sup> rmany	
			-	Usual Residence of Decedent									1						
	w any		10a. State 10b. County 10c. City, Town or Location  Maryland Montgomery Bethesda											10d Inside City Limits 1 Yes 2 X No					
	ryland a-f sho	į	٤	Maryland   Mont		1	betnesc	121 10f. Zip	n Code				10g Citi						
	he Ma or 28		Director	7559 Spring Lake Drive Apt				C2			20817				rog Citi		u <b>y</b> r		
	r death with the Maryland or items 23a or 28a-f show	1	╗┞	11. Marital Status		12. Was Dec	edent Ever			Decede	ent of Hisp			cify Yes or N	lo-	USA 14. Race -		can Indian, Black,	
	death or iter	Filbor	<u></u>	1 Never Married 2 XXMarried Armed Forces? 1 Yes 2				No	If Ye	s, speci	ify Cuban,	Mexican,	Puerto R	ican, etc.)		White,	etc.		
	s after		⋧┞			If Yes, Give Year or Dates:		- d)   46			No No		1. 4 -6			Specify. W	_		
	2 hour	7	ᆰ	<ol> <li>Decedent's Education (Sp Elementary/Secondary (0-12</li> </ol>		College (1		ea) 16	Sa Decedent's during mos						16b F	Kind of Busi	ness/lr	ndustry	
	thin 7. than	1	ouibiered	,,		5+	,		Medical Doctor							N.I.	Н.		
	5-0036 lled within 7 Hygiene I other than	3	וי	17. Father's Name (First, Middl	. ,				-		1:			First, Middle,					
	2121 ould be fil Mental F marked	6		Georg A. G				-	10b Mailine	A alaka a a	. (0)			nna M.					
	imore, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene rant: If item 27 is marked other than "natural", or items 23a or 28a-f shown in the control of the	1	- 1	Sandra Kay Rob			nd	11	19b. Mailing /									and 21286	
	e, N I and Health item		1	20a. Method of Disposition			2		ce of Disposit	ion (Na	me of cem			Date		Location - C			
	Pages ent of nt: If			1 Burial 2 X Crematic 4 Donation 5 Other		Removal fro	m State		natory or othe ro Crer			nc.	11/	11/06	Ba	ltimo	re.	Maryland	
	Baltimore, permit. Pages I at Department of He Important: If ite		- 1	21. Signature of Funeral Service		see	0.		22. Na	me and	Address								
			1	21. Signature of Funeral Service Licensee  Thomas Gregor  Thomas G											and 21228				
	Physicia /Medica			failure. List only one cause on each line.  Between Onset a											Approximate Interval Between Onset and				
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	O, be executed sician and	<u> </u>		X AMENDED #11, perFH/attorney C871, 9/5/07 TT #23a, PII, 27, perME, C861, 11/16/06 TT 4a-b, perME,															
	o pe	Logi		F FEMALE:	_λ	23c. If yes, o				G861	,11/16	/06 T	<u>r</u> 48	a-b, per	<del></del>	d Date of de	aliven		
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	Box e death of the atten	, ioi	2	1 Yes 2 No 9 U	known	9 Unkno	ant at time o	of death	5 Othe	er (Spe	ecify)								
	that the d	2		Part II. Other significant cond	tions			not resu	Iting in the un	derlying	g cause giv	ven in Par	t I.	23e. Did	tobacco i	use contribu	ute to ti	ne cause of death?	
	ires that the signed by t	ं   र	3	Atherosclerotic	car	diovascu	lar di	sease	2					1 Ye	es 2	No 3	Proba	ably 4 🗸 Unknown	
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	n of ding Ph	5	<u>.</u>	27. Manner of Death  1 X Natural 5 Per	idina	28a Date of (Month,	Day.Year)	28	Bb. Time of Inj	ury	28c. Injury	es 2 1	i	8d. Describe	how inju	iry occurred			
	ivisior or Attend after death Director:	ortification.	5	2 Accident Inve	estigatio	28e Place	of Injury -	At home	e, farm, street,	factory				Bf. Location	Street ar	nd Number	or Rura	al Route Number, City	
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	(2)		1	30. Name and address of perso Ana Rubio MD. As		ompleted caus it Medical E		,		reet, E	Baltimor	e, MD 2	21201						
		Stat	_	31. Date filed (Month, Day, Year	)	32 Re	gistrar's Sig		Ann	00 p									
	Regi	stra	ìΓ	NOV 1 4	200	b B	Post Race	13	S. C. C.	S. C.									

State of Maryland / Department of Health and Mental Hygiene 35929 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 12 Year **Physician** 07.09 AM November 20,00 Edward David Gable Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10XM 2□ F Director Nov. 22, 1949 Maryland 220-50-1280 56 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location wode | or 28a-f show a notified at 10d. Inside City Limits 1 ☐ Yes 2√ No Directo Maryland Harford <u>Abin</u>gdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r then "naturel", or Items 23a or the Wedical Examiner must be 7 Mitchell Drive 21009 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status is 1 and 2 should be filed within 72 hours atter of Health and Mental Hygiene. Item 27 te marked other then "naturel", or Ite other freumatic event, Ine Mudical Estimina 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 25 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Chairman of the Board Telecommunication 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward David Gable Sr. Dorothy Brent McLain ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an 7 Mitchell Drive, Abingdon, Maryland 21009
20c. Location - City or Town, State Helen B. Gable/ Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 Z Cremation 3 ☐ Removal from State = ö permit. Pag Department Importent: I eny Injury c Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp 11-14-06 21. Signature of uneral Service License McComas Funeral Home, P. A. 1317 cokesbury Rd., Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Sta **Physician** resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Exam Due to (or as a consequence of) of Vital Records, P.O. Box 68760 Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the e 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the autopsy performed? 1 Yes 2⊠No 1 ☐ Yes 2 ☐ No efter death. Director: After this certific Jin by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital or within 24 hours e To the Funeral C completely filled filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. ţ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0056607 November 12th, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSEPH ANGELC, 602 S. ATWOOD Rd. # 205: BELATIR MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 1 4 2006

M000059156

Edward

32. Registrar's Signature

			1 - For State Registrar	State of M	aryland / De	epartme C <i>ertifica</i>				20	06	25020		
			Decedent's Name (First, Middle, Last	)		307111100	10 07 2		2. Date of De		0.0	3. Time of Death		
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	Examir		4a. Facility Name (If not institution, give					Location of Deat	th	4c. Count	y of Death			
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	Funeral Director		5. Social Security Number 6. Sex 1 Months 1 Mont							th y, Year)	Cour	lace (State or Foreign itry)		
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	ehow	_	10a. State 10b. County		10c. City, Town o	or Location					1	Od. Inside City Limits		
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	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f ehow he Madical Exeminer must be inclified at	Completed by Funeral Director	14208 Dove Creek	Way #206		10f. Z	ip Code 2	21152		USA	log. Citizen of What Country?			
1/1	ems 2	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Dec	edent of His	panic Origin? (S	Specify Yes or No to Rican, etc.)	- 14. Ra	ce - Americ			
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Jud	uld be filed fental Hyg rked other ilc event,	Be	17. Father's Name (First, Middle, Last)						me (First, Middle,		ne)			
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₩	and 2 she ealth and n 27 ie my		Kathryn A. Bauer/	•					aral Route Numbe			Code)		
ore,	- I 5 =		20a. Method of Disposition	<u> </u>	20b. Place of D cemetery,				Date 4/06	20c. Location		wn, State		
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	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		SRUST	3	-					lodazi		
	Examiner			Due to (or as	a consequence of):	: 6	.	e3 5				Lada		
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JS,	8 69	by Physic	Part II. Other significant conditions con	tributing to death bi	ut not resulting in th	e underlying	cause given	in Part I.		/		cause of death?		
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Rec	hes l	Completed							24a. Was a autop perfor	sy p	Were autoportion to com death?	sy findings available pletion of cause of		
<u>a</u>	yeician: The is certificate he director, page		25. Was case referred to medical						1 ☐ Yes	2.2 No 1		2□ No		
ž	yeicis is cert direct	To Be	examiner?	ospital: Inpatie	nt 2 ER/Outpa	tient 3□ D	Other		th <i>Check only or</i> ome 5 ☐ Resid					
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Sio	ttendir death. stor: Al	catic	2 ☐ Accident investigation	(	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	м		s 2 No						
Division of Vital Records, P.O. Box	To the Hospitel or Attent Within 24 hours effer death To the Funerel Director: cumpletely filled in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc	ury - At home, farm, c. (Specify)	street, factor	y, office		28f. Location (S City or Tow	treet and Numb n, State)	er or Rural	Route Number,		
_	Hospitel or 24 hours efte Funerel Dir tely filled in I		29a. Certifier 1 Certifying Phys	ician: To the best of	of my knowledge, de	eath occurred	at the time.	date and place	and due to the c	ause(s) and ma	oner as sta	tod		
	he Ho n 24 h he Fu pietely	Medical	(Check only 2 Medical Examin one)	er: On the basis of and manner sta	examination and/o	rinvestigation	i, in my opin	ion, death occur	rred at the time, d	ate and place,	and due to	the cause(s)		
	To the Within 2 To the cumplet	Σ	29b. Signature and title of certifier			29	c. License r	umber	Cic - '	9d. Date signed	(Month, D	ay, Year)		
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(,	0			mpleted cause of de	eath (Item 23a) (Ty	pe, Print)	, c+	color		34.	60			
	Stat	е	31. Date filed (Month, Day, Year)		ar's Signature	A STATE OF THE PARTY OF THE PAR	3 4 )	300,10	man IN	12612	-			
	Registra		NOV 1 4 2008	A DECEMBER	1 1 1	24/2								

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Gold Agota 9 2006 1:00 AM November /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Roland Park Place Healthcare Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yes 2–18–1924 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2XX Months Days Hours Min. 82 217-38-0656 Director Poland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show a or 28a-f sh N/A 1 X Yes 2 No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apartment 358 21211 USA 830 W. 40th Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes **2** X No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes XX No Specify white <u>Ş</u> 3€Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Librarian Johns Hopkins University 4 permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margit Agost Vidor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark B. Vidor Cousin 258 Stanmore Road Baltimore, MD 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Metro Crematory 11/10/2006 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 23a. Part1. Enter the disease, or compli-shock, or heart failure. List only on Approximate Interval Between Onset and Death ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and Due to (or as a consequence of) P.O. Box 68760. attending physiciar Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? þ Month Year Day 5 ☐ Other (specify) the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. 9 2 1 □ Yes 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? perforn 2□ No 1 Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificd completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2/X No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 TYes 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 2 ☐ Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖟 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

State Registrar 30. Name and address of person with

4

31. Date filed (Month, Day, Year)

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and manner stated.

II, M.D.

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

completed cause of death (Item 23a) (Type, Print)
16-1ACT, III, M.D. 6301 N. CHARLES ST, BALTIMORE MD 21212

29d. Daye signed (Month, Day, Year)

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-	2		Future Care 5. Social Security Number	6. Sex		rs. last birthday	If Under 1		ersto		Dieth				
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	1 and 2 Health a lem 27 is		Darlene Gee-I	Daughter			_			ve Apto	C, Ba	alto	Mo	2122	29
Baltimore,	00-		20a. Method of Disposition  1 Burial 2 Cremation	3 □Removal from	State 20b.	Place of Dispo cemetery, crei	sition (Name of matory or other	of r place,	)	Date	20c. L	ocation - C	ity or To	wn, State	
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	To the Hospital or At within 24 hours effer of To the Funeral Direct completely filled in by	edical	CHOCK ONLY S MEDICAL	ng Physician: To the Examiner: On the ba	best of my kr	nowledge, death	occurred at th	ne time,	date and pla	ice, and due to th	e cause(s)	and mann	er as sta	ited.	
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,	30. Name and address of person was completed cause of death (Item 23a) (Type, Print)  Silen Hett (eman 1838 Greene Tree										- 1	16/	00		
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day **Physician** AINE 11:00 AM NOVEMBER 4 200 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OF MARYLAND MEDICAL CTR BALTIMOR BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 V Months Davs Hours Min. 251-84-6054 Director 28 SC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Catonsville 1 ☐ Yes 2 X No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1518 Rawlings Well Road 21228 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ∏Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify Completed by Specify: 3 ☐ Widowed 4 X Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) llth grade na Food Service BWI Airport 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Clem Evans Claudia Mumnford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 21228 19a. Informant's Name/Relationship (Type. Print) Annie Evans-Robinson-Sister 1518 Rawlings Well Road, Catonsville, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □Removal from State King Memorial Park 11/9/06 Randallstown, Md 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License March F/H West ala 4300 Wabash Ave, Baltimore, 21215 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MYOCARDIAL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to influed at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to by as a consequence off Examine the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 No Nown Completed Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed' certificate 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Injury at Work? 5 Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No hours after death. Director: / 6 Could not be determined 3 ☐ Suicide . Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hours the Funeral Directory filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2. To the I 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar ANDRA

31. Date filed (Month, Day,

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Year)

DHMH 17 Rev 1/2001

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Registrar's Signature

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32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** William Albert Graves 4:30 p November 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 945 Elton Avenue Dundalk Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 1 → M 2 □ F 42 Director 215-78-9204 Feb 26, 1964 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD the Medical Examiner must be notified Baltimore Dunda1k Director 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 945 Elton Avenue 21224 by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 ☐ Widowed 4 ☐ Divorced Specify: white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Fork Lift Driver Warehouse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any linjury or other traumatic evonce. Collis McCubbins ည Virginia Lillian Graves 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Gilday/Aunt 905 Brice Road Rockville MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 P 4 Oonation 5 Other (Specify) 3 ☐Removal from State West Arundel Crematory 11-09-2006 Odenton, Maryland 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 21. Signature of Funeral Service bicensee 23a. Part1. Enter the disease, or complications that caused the death. Do you enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 2719 Hammonds Ferry Rd. Lansdowne MD 21227 Immediate Cause (Final disease or condition resulting in death) Physician LUNG CANCER WITH METASTASE PROBABLE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 24 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 enguasane MO November 8, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

VERGARA - GOARES

31. Date filed (Month, Day, Year) 16 1 2006

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32. Registrar's Signature

FRANKLIN SONARE DR. BAITIMORE, MD. 2123.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle Last) Month Dav **Physician** (Z:45 PM November 2006 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 1-lizabeth uvsina timore Center a If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In. yrs. last birthday) 5 Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 □ M 21 F 86 215-05-6268 Director 30, 1919 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h Count 10a. State Items 23s or 28e-f ehow other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 1 No Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 United States 3320 Benson Avenue, Rm 326 Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. Int: If Item 27 Ie marked other then "naturel", or Items 23. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24D No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Otto Carl Angermaier Helena Mary Healey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 704 Doages Drive, Millersville, MD 21108 Robert C. Grimm - Son 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Organis Cematory of other place)
(Veterans Cemetery 11-13-2006) 5 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Crownsville, MD 4 □ onation 5 □ Other (Specify) Name and Address of Facility Ambrose Funeral Home, Inc. of Funeral Service Liceosee 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final 0 **Physician** resulting in death) /Medical Examiner ear Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Medical Certification: To Be Completed by Physician/Medical Examiner Due to (or as a consequence of) use as the burial-transit or Attending Physician: The law requires that the death certificate be executed sicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Onknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform notheroidism 2 🗆 No certificate 2 No 1 Tyes 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4X Nursing Home 5 - Residence 6 - Other (Specify) 2 ER/Outpatient 3 DOA this : After this funeral 27. Manner of Death
1 A Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu investigation 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or At within 24 hours after of To the Funerel Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar Baltimore

Name and address of person who completed suse of death (Item 23a) (Type, Print)

1 1 1 2 3 2 0 13 - 20 11 - 20

32. Registrar's Signature

31. Date filed (Month, Day, Year)

1 4 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene dr. 1331, 11 per dr. 1361, 11, 14,06dhb Reg. No. Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician 00:25 AM October 30 2006 LAWRENCE PRESTON HUMPHREY /Medical 4c. County of Death N/A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE UNION MEMORIAL HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min 1 x M 2 □ F 75 241-44-1052 Director 7-6-1931 NORTH CAROLINA Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show **Funeral Director** 1 X Yes 2 □ No BALTIMORE N/A MD. 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or must be USA 2713 FENWICK AVE permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ in once. . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Tyes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify ģ Specify: BLACK 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MACHINE OPERATOR SCHAEFFER BREWERY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ MELTON HUMPHREY MARY BOONE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2713 FENWICK AVE. BALTIMORE, MARYLAND 21217 EDITH HUMPHREY(WIFE) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 □ Removal from State 4 Donation 5 Other. GARRISON FOREST VETERANS OWINGS MILLS, MARYLAND 21. Signature of Fun ral HIBNERName and Address of Facility PHILLIPS FUNERAL HOME, P.A. re **∤**1721**–**27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. Filer the disease, or components, in heart failure. List only Immediate Courte (Final disease or condition resulting in death) death. Do not enter the mode of dying, such as cardiac or respiratory arrest Urinary Track Infection or complications that caused the **Physician** /Medical Sepsis Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed Methicillin Sensitive Staphylococcal Aureus Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by End Stage Renal Failure 1 Yes 2 No 3 Probably 4 Donknown Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No End Stage Heart Failure autopsy perform 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 24 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) moric 32 Registrar's Signature State 2006 Registrar

			1 - For State Registrar		State o	f Maryla		artmer			and M	ental Hyg	giene 10g. No2 (	106	350	137
	Physici	an	Decedent's Name (First,     Evelyn S			<del></del> -						2. Date of Dea Month	ith Day	Year	3. Time of	Death
	/Medic Examin		4a. Facility Name (If not in:	stitution, give s	street and nu			4b. City,		Location of		Nov		2006 nty of Death N/A	15/5	
	Funeral Director		5. Social Security Number 368–16–9881	6. Sex	-		s. last birthday, 86 Yrs.	If Under Months		If Under Hours		8. Date of Birth (Month, Da) NOV 24,	1919		olace (State or otry) higan	Foreign
	Maryland f show	ō		ent County altimon	<b>~</b> e	10c. C	City, Town or Li		Δ					1	0d. Inside Cit	
	h with the ? 3a or 28a- at be notif	ai Director	10e. Street and Number 707 Maiden				Caron	10f. Zip	Code	228			10g. Citizen o	f What Cour	ntry?	
920	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "netural" or Iteme 23s or 28s-f show sumatic event, the Modical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2[ 3 Widowed 4 Directions	Married	12. Was Dece Armed Fo 1 (TXYes If Yes, Giv Year or D	2 No 12	943	Was Dece If Yes, spe 1  Yes		spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto I	city Yes or No- Rican, etc.)		ace - Americ lack, White,		
altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be flied within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netur any injury or other traumatic event, the Medical once.	Completed	15. De (Specify only Elementary/Secondary ( 12	cedent's Educ highest grade 0-12)	cation completed) College (1	1-4or 5+)	(Give	dent's Usua kind of wo DO NOT us emake	rk done d se retired	ation Juring most	t of workii	ng	16b. Kind of Own	Business/In Home	dustry	
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re, Mar	t and 2 sh Health and tem 27 is m other traum		19a. Informant's Name/Re  William H.  20a. Method of Disposition	Hyde,	•	nd 20b.		Maide	n Ch	oice	Lane	Catons		MD 2	1228	
altimo	permit. Pages Department of I Important: If Ite any injury or of		1 Burial 2 Crem 4 Donation 5 Of  21. Signature of Funeral S	ervice Lin Glad		Jiaio	etro Cr	emato	ry I	nc.			Baltim	ore, l	Marylan	nd
	8 9 E E 8		Thomas G  23a. Part 1. Enter the disershock, or heart failure	regor ase, or complic	cations that c	aused the dea	ath. Do not en	99 Fr	eder	ick R	load cardiac o	f Maryl Baltimo	and, In re, Ma <sup>est,</sup>	rylan	Approximate	1
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	C a	S	(or as a conse	quence of):  OWCY L	inh	Tscl	10 100 11	$\gamma$		- 1		Onse and D	eath YS
129,	cuted nd ransit	Examiner	Sequentially list currentions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events	• {		or as a conse	quence of):								20a	73 45
8760,	cate be executed physician and the buriat-transit	dicai	resulting in death) Last	d	Due to (	cute 1	ant H quence of): Renal	Fail	ure						20a	ys.
.O. Box 6	I the death certification by the attending ached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 No 9 ☐ Unknown	all I	1 Live b	come of pregn irth 2  Fet ant at time of o	aldeath 3[	]Ectopic pr ] Other (sp						ate of delive		ear
n Records, P.O.	w requires that been signed t should be det	ed by P	Part II. Other significant co	Artery	tributing to de		Chror	nic A	trial			23e. Did tot		atribute to th	e cause of de	eath?
// Rec	Inelaw ate has b page 2 s	Completed by	Fibrillat	ion,	peri	pheral	Vasc	ular	Du	euse		24a. Was a autops perform	n 24b y ned?	death?	osy findings a npletion of ca	vailable use of
$\sqrt{de}$ , $Evel$ Division of Vital	Attending Physician: In r death. setor: After this certificate by the funeral director, pag	To Be			-	patient 2 Dof Injury h, Day Year)	ER/Outpatier 28b. Time of Injury		8c. Injury Work	r: 4 🗆 Nur	sing Hom	Check only on se 5 Reside 8d. Describe ho	e ince 6 □Oi		)	
14de	to the Hospital or Attending Physiking 24 hours after doesth. To the Funeral Director After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ 0	Could not be determined	28e. Place buildir	of Injury - At h	nome, farm, str ify)	eet, factory	, office		2	8f. Location (St City or Town	reet and Num , State)	ber or Rura	l Route Numb	e <i>r</i> ,
	in 24 hours and the Funeral Inpetelly filled	edicai	29a. Certifier Ce (Check only 2 Me	rtifying Physi dical Examin	ician: To the er: On the ba and mann	isis of examina	owledge, deat! ation and/or in	n occurred vestigation,	at the tim in my op	e, date and inion, deat	place, a	nd due to the ca d at the time, d	use(s) and mate and place	nanner as st , and due to	ated. the cause(s)	
		Σ	29b. Signature and title of c	Cetito	>			A	License		2831		od. Date sign	·	Day, Year) . 2006	
	87	`	30. Name and address of p Gerard De	Castro	900 1	Caton A	he. Bo			MO						
	Stat Registra		31. Date filed (Month, Day,	Year)		egistrar's Signi	ature	DAN'S								

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

Amend Item 10d per SA, G861, II/16/06dhb

Amend Items 28a e per MF. G861, II/14/06dhb

Certificate of Death

Rag. No. 2 35938 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Andrew G. Holman October 0 24, 2006 10:06 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3514 Forest Hill Road Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 4, 1923 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Months 1♥M 2□F 83 Yrs 192-14-1262 Pennsylvania May 4, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 <del>Vos</del> 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 3514 Forest Hill Road USA 12. Was Decedent Ever in U.S. Apped Forces?

1 △ Yes 2 □ No
If Yes, Give 1 / 2 - / 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: white If Yes, Give Year or Dates: 43-46 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 0 furrier clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Edward Holman Julia Promik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence Holman/son 4517 Old Court Road Pikesville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) 21. Signature of Euroral Service Licensee Ronald . Wade Dyrector State Anatomy Board 655 W. Baltimore Street 2000 21201 Baltimore, MD 25a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CAS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) heart 610 Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2/No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 Pending 14/34 Piline investigation 1 Yes 2 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Straet and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The law requires that the death certificate be executed P.O. Box 68760. Division of Vital Records. Attending Physician: s effer dea. ö Hospital

Physician

/Medical

Examiner

10a. State

Director

Completed by Funeral

Be

Examine

Physician/Medical

Be Completed by

Certification: To

Medical

**Funeral** 

Director

ir then "natural", or Items 23a or 28e-f ehow the Medical Examinar must be notified at

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filed within 72 hours after

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After this certific funeral director.

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Baltimore, Maryland 21215-0036

State

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VIOLOR MADRID 31. Date filed (Month, Day, Year) NOV 1 4 2006 Registrar

(Check only one)

29b. Signature and Atle of certifier



MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CERPETED. 700 met.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

10058046

CATOMSVILLE

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of Ma	arylan		artment o				giene	06	359	339
			Decedent's Name (First, Middle, Last)	1					·	2. Date of Dea	ath		3. Time of	f Death
	Physici /Medi		Isaac S. Harmon	n, III						Month Novemb	er 8,	Year 2006	1:26	РМ
	Examir		4a. Facility Name (If not institution, give :	street and number)			4b. City, Tow	n, or Location	of Death			ty of Death		
			Greater Baltimore					Towson			Ba1	timor	e	
	Funeral		5. Social Security Number 6. Sec. 215-32-2640	7. Ag ¶M 2□F	10 (In yrs. 1	last birthday) Yrs.	If Under 1 Ye Months Da			8. Date of Birt (Month, Da	v, Year)	Cour	place (State o	or Foreign
	Director		Usual Residence of Deceden			113.				June 11	, 1935	Mar	yland	
	yland		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside Ci	ity Limits
	a-fe	io	Maryland Baltimore	2			Nott	ingham					1 🗌 Yes	2 XNo
	or 28	Director	10e. Street and Number				10f. Zip Cod				10g. Citizen of	What Cou	ntry?	
	ath w		2 Durban Court, A	Apt. D				21	236		и.:	S.A.		
$\bigcirc$	rs after death with the Marylar ", or Iteme 23a or 28a-1 ehow ramater must be notified at	Funeral		12. Was Decedent Armed Forces?		S. 13. V	Vas Decedent of Yes, specify C	of Hispanic O Juban, Mexica	rigin? (Spe an, Puerto l	cify Yes or No- Rican, etc.)	14. Ra Bla	ce - Americack, White,		
36	irs aft	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 1 If Yes, Give Year or Dates:	No	1	☐Yes 2💢 I	No Specify	<i>/</i> :		Speci	ity: Blo	ıck	
APO	within 72 hours after death with the Maryland ane. than "nature!", or Iteme 23a or 28a-f ehow he Medical Examinat must be notified at	ted	15. Decedent's Edu	cation		16a. Deced	ent's Usual Oc	cupation			16b. Kind of I	3usiness/Ir	dustry	
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<b>~ 2</b>	ed wi	Completed		5+		Princi	pal & 1	Pirect	or-Adi	ult Ed.	Public	School	ols	
25	be fil ntal H od oth	Be	17. Father's Name (First, Middle, Last)	77						(First, Middle,		me)		
<u>≥</u> <u>≥</u>	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Na	ç	Isaac S. Harmon,  19a. Informant's Name/Relationship (Ty)			405 44 75-			ary	Speak				
HATMOY Baltimore, Maryland 21	ロモトコ		Catherine P. Harmo		0)	1				i Route Numbe Notting				
A 5.	permit. Pages 1 an Department of Heal Important: if Item 2 any injury or other once.		20a. Method of Disposition			ace of Dispos	sition (Name of atory or other;	, Apr		ate	20c. Location			
- P	Pages ent of nt: # I		1 Donation 5 ☐ Other (Specify)	emoval from State			atory or other; Redeen		11/11	/2006		•		
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ä	Depa Impo Any i		Staperres	Rine	ke					altimor			,,	
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused e cause on each lin	the death	. Do not ente	r the mode of o	tying, such a	s cardiac o	r respiratory ari	est,		Approximate Interval Bety	
	Physician		Immediate Cause (Final disease or condition	a	2549	tole	•						Onset and E	
	/Medical Examiner		resulting in death)	Due to (or as	a coosequ	ience of):								
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9	The law requires that the death certificate to has been signed by the attending ptrys bage 2 should be detached for use as the	ledi									100		- 02 0	
Box	leath certific attending p	Physician/Me	230. Was decedent pregnant	3c. If yes, outcome a			Ectopic pregna	DCV			23d. Da	ate of delive	ery	
	at the dea by the at tached fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at 9☐Unknown			Other (specify)				M	onth	Day Y	/ear
Ρ.	hat thid by detach	P.	9 ☐ Unknown  Part II. Dther significant conditions con	tributing to dooth by	ul mal sagu	bine in the co	test de la company			00 0111				
Division of Vital Records, P.O	w requires that been signed t should be deti	Completed by	Durch CL	A mile Car	4 6v.		deriying cause	given in Part	1.	23e. Dig to	bacco use con	tnbute to th 3 ☐ Prob		
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<u> </u>	Physician: this certificanal director,	To Be	examiner?	ospital:	nt 2 🗆 E	R/Outpatient	3□ DOA	34L		(Check only on ne 5 ☐ Reside				
5	ig Ph ter thi		27. Manner of Death	28a, Date of Injur (Month, Day	v	28b. Time of Injury	28c. In			8d. Describe ho			7	
Si	Attending F or death. ector: After by the funer	atic	1. Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	76417	injury		Yes 2	No					
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	Hospital		00-0-4											
		Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	er: On the best of and manner sta	examinati	rledge, death on and/or inve	occurred at the estigation, in m	time, date ar y opinion, dea	nd place, a ath occurre	nd due to the cand at the time, d	ause(s) and ma ate and place,	anner as stand due to	ated. the cause(s)	J
_	To the within 2	Me	29b. Signature and title of certifier	and mainer sta			29c. Lice	nse number		2	9d. Date signe	d (Month.)	Dav. Year)	
	C > F 0		> Translan	002	M	0	DA	1001	87		11/0	100		
	(1		30. Name and address of pers who cor	npleted cause of de	eath (Item	23a) (Type, P	rint)	1200	0 2		11/7	100		
2	0		6535 No Cha	rles	Sui	te 5	50	1580 Town	en.	MD	2120	14		
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ŧ	Physici	an.	1. Decedent's Name (First, Middle, La	ist)							2. Date of Deal		Year	3. Time of Death
	/Medic		Reed Jay Hetherin								November	<u>r 11                                   </u>	2006	12:30 AM
	Examir	er	4a. Facility Name (If not institution, given 111 Hamlet Hill H					Town, or I timor	Location of	f Death		4c. County		
	Funeral		5. Social Security Number 6.	Sex 7. A		last birthday)	If Under	1 Year	If Under 2	4 Hrs.	8. Date of Birth		9. Birthpl	lace (State or Foreign
A.	Director		184-18-0961	1 <b>∑</b> M 2□F	8	4 Yrs.	Months	Days	Hours	Min.	April 16	5, 1922	_Coun	nsylvania
	and		Usual Residence of Decedent  10a. State 10b. County		10c, Cit	y, Town or Lo	cation						1/	Od. Inside City Limits
	Maryli f sho	lor	Maryland N/A			altimo								1 X Yes 2 □ No
	r 28a	rec	10e. Street and Number				10f. Zip	Code			1	0g. Citizen of	What Coun	try?
	th with	aiD	111 Hamlet Hill H	Rd., Apt.	510		21	1210				United	Stat	es
	teme	Funeral Director	11. Marital Status	12. Was Deceden	?	.S. 13. \	Nas Deced f Yes, spec	ent of His	panic Orig	in? (Spe Puerto	ecify Yes or No- Rican, etc.)		ce - America	
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Š	within 72 hours after death with the Maryland ene than "natural", or Iteme 23a or 28a-f show the Medical Examinar meet by notified at	ted	15. Decedent's E	ducation		16a, Deced	lent's Usua	Occupat	tion			16b. Kind of B		
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land	should be filed within and Mental Hygiene le marked other than aumatic event, La Mi	To Be	Raymond J. Hether								o (First, Middle, A Colvin	walden Sumar	n <i>e)</i>	
Maryland 21215-0036			19a. Informant's Name/Relationship Martha V. Hetheri	•	2						APt. 510	City or Town,	State, Zip	Code)
<u>6</u>	Health Health tem 27		20a. Method of Disposition		20b. P	Place of Dispo						20c. Location	· City or Tov	wn. State
altimore,	Pages nent of t int: If it		t ☐ Burial 2 XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		-				1	OV.	14,2006			Maryland
ä	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lice		r Gre									
<u> </u>	9 9 E 6 9		John V. M	tchell			65	00 Y	ork R	ld.	feld Fun Baltim	ore, M	D 212	212
8760, 8	Characteristicate be executed by Medical Examiner of for use as the burial-transit	licai Examiner	23a. Party Enter the disease, or conshook, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CVA Due to (or a	ine.  ion F s a consequence of a consequ	neumon uence of):								Approximate Interval Between Onset and Death 24 hours
.O. Box 68	res that the death certificate bigged by the attending physic be detached for use as the b	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic pre					23d. Da Mo	te of deliver	Ƴ Day Ƴear
S,	es that igned b	by P	Part II. Other significant conditions	contributing to death	but not resi	ulting in the ur	nderlying ca	use giver	in Part I.					e cause of death?
ord	w require been sign	eted	Parkinson's								1 □ Ye	s 2XNo	3 Proba	ıbly 4 □Unknown
Records,	has has	Completed									24a. Was ar autopsy perform	ted?	Were autoporior to com death?	sy findings available apletion of cause of
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7	d is y	ဥ	1 ☐ Yes 2 📉 No			ER/Outpatient				sing Hor	ne 5 X Reside	nce 6 □Oth	er (Specify)	)
כם	De joi e	tion	27. Manner of Death  1 XNatural 5 ☐ Pending 2 ☐ Accident Investigatio	28a. Date of Inj (Month, D	ay Year)	28b. Time of Injury	M 28	3c. Injury a Work?	at ∋s 2 ⊡ N		28d. Describe ho	w injury occuri	ed	
Division of Vital	al or Attending s after death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could not b	e 28e. Ptace of Ir	njury - At ho	me, farm, stre			55 2		28f. Location (Str		er or Rural	Route Number,
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	To the Hospital of within 24 hours at To the Funeral D completely filled in	edical (	29a. Certifier 1 ★ Certifying Pf (Check only one)	nysician: To the bes niner: On the basis and manner s	oi examinat	wledge, death tion and/or inv	occurred a estigation,	it the time in my opii	, date and nion, death	place, a	and due to the ca ed at the time, da	use(s) and ma ite and place,	nner as sta and due to	ited. the cause(s)
	within To the comple	Me	29b. Signature and title of certifier	1.1				License				d. Date signe		Pey, Year)
			I July 15	West 1_	M	0	D	45	42	(	1	1/13/	06	
	7		30. Name and address of person who	completed cause of	death (Item	23a) (Type, I	Print)	0.4		. (	7			MD 2109
2	Sta	0	31. Date filed (Month, Day, Year)	X II DULD	n, M	D J	D.E.	HOOL	onu	ak	ea lin	nonic	m, 1	41) 2109
Nowa A	Registr	-	NOV 1 4 200		1	ture	also de la constantia della constantia della constantia della constantia della constantia della constantia d							

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State of Maryland / Department of Health and Mental Hygiene UU5 Certificate of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) 3. Time of Death Month Year Physician 8:00 A M Constance May Hudson November 9, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Forest Hill
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Harford Forest Hill Health & Rehab Ctr. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeal May 26, 1 **Funeral** Days Min. 1 M 20 F Months Director 351-14-0818 83 Illinois 1923 Usual Residence of Decedent death with the Maryland 10a State 10c. City, Town or Location 10d, Inside City Limits 10b. County Item 27 is marked other than "naturel", or Itema 23a or 28a-f ebov other treumatic event, the Madical Examinan most be notified at 1 Yes 2 No Director Forest Hill Maryland Harford 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? USA Funeral 1 Colgate Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: if Item 27 is marked other than "naturel", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 ₩ Widowed 4 Divorced White Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Public Schools 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be John (nmn) Holstrom Anna (nmn) (unk) P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ladd/ Executor
20a. Method of Disposition 1001 Leeswood Rd., Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If Ite eny injury or ot once. Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify)

21. Signature of Fireral Species Eigensee Bel Air Memorial 11-11-06 Bel Air, Maryland 22. Name and Address of Facility
McComas Funeral Home, P. A. 50 West Broadway, Bel Air, Maryland 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest so on each line. Immediate Cause (Final lle **Physician** disease or condition Sepain resulting in death) /Medical Due to (or as a consequence of) Examiner chunce Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit perplued vasa that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached to 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably A Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has b lirector, page 2 s autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ို 1 ☐ Yes 2 ☐ NQ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D32255 November 10, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Belair mas 615 W. Mac Phanl Donn Down D 3. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

NOV 1 4 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Emily Perry Hanson November 6, 2006 5:24 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Hart Heritage Street Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours 1 ☐ M 2(XF Director 216-05-7730 93 26, 1913 Washington, DC Usual Residence of Decedent 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at Director 1 Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 101 Eastern Ave. 21014 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify: 3 ₩idowed 4 Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2121 al Hygiene. Pages 1 and 2 should be fited within Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Health and Mental la marked Mitchell McHenry (nmn) Laura Perry Dreschler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If itam 27 la any injury or other trau once. 101 Eastern Ave., Bel Air, Maryland 21014 Dave Hanson / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 11-8-06 Towson, Maryland 21. Signature of Fungal Service License 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complicators by a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on death line. Approximate Interval Between Onset and Death Consestive Heart Failure Immediate Cause (Final Physician disease or condition resulting in death) years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760 attending physician Physician/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ö in the past 12 months? 1☐ Yes 2⊠No Day Month Year 5 Other (specify) \_ 4□Pregnant at time of death P.O. the 9 Unknown 9 ☐ Unknov ģ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. by 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an rmed2 2 No 1 ☐ Yes Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be Assisted 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence ther (Specify) 1 ☐ Yes 2 No 2 28c. injury at Work? 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Certification: Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Registrar DHMH 17 Rev 1/2001

within 2

٥

Medical

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DUGRAD SPAMY

NOV 1 4 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MA

32. Radistrar's Signature

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TANSEN

615 W. MARPHOLL

GORALL.

D39889

Bel AIN MD 21014

29d. Date signed (Month, Day, Year)

7,2006

	Physician
	rilysiciali
	/Medical
	Examiner
-	

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a.4 a.t. any injuy or other traumatic event, the Medical France.

Physician /Medical Examiner

attending physician and for use as the burial-transit death. neral Director: , y filled in by the f

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

within 24 hours a

Division or Vital Records, P.O. Box 68760,

4, 2006 15:09 November 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital Baltimore City If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year)
May 17,1944 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🗓 F 218-42-7885 62 NC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Director MD Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 926 Kinhard Court 21146 Funeral U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 Never Married X Married 2 No 1 ☐ Yes 2 No White Specify To Be Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Huges Foster Mary Potter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Mark A. Herner / Husband 926 Kinhard Court Severna Park Maryland 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Nov.9, 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2006 Maryland Vets Cem. A⊞Donation 5 ☐ Other (Specify) Crowsville, MD 22. Name and Address of Facility Singleton Funeral Home, P.A. 21. Signature of Funeral Service Licensee Second Avenue SW Glen Burnie MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE MYELOGENOUS LEUKEMIA 1 MONTH disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 4 Pregnant at time of death 9 Unknown Month Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No å 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4,2006 RES-000 MD NOVEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREET 600 NORTH WELFE WOLFE BALTIMORE, MD 21205 NAIK

Herner

Day

State

Registrar

31. Date filed (Month, Day, Year)

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 2:37 AN 2006 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE MARYLAND MEDICAL SY BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F 216-92-6268 20, Director 1962 WI Oct. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2 No MD Severna Park Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21146 USA 33 Emerson Rd. 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No White Specify. ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Engineer Software 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas M. Himmelmann ျ Kay L. Ehrensberger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Jeffrey Harding/Husband 33 Emerson Rd., Severna Park, MD 21146 20b. Place of Disposition (Name o 20a. Method of Disposition 20c. Location - City or Town, State Fairfield Baptist 1 ★ Burial 2 Cremation 3 Removal from State Burgess, VA 4 ☐ Donation 5 ☐ Other (Specify) 2006 Church\_Cemetery 21. Signatu Wu rat Service Licensee 22. Name and Address of Facility 1 Second Ave. SW M01411 Singleton Funeral Home; Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** OLORECTAL 11/2005- 11/2006 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Spinal coid compression 1 🗌 Yes Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? verte bran perform 2 No 2 No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA After this funeral Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29 . Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b, Signature and tinte of certifier 29c. License number 29d. Date signed (Month, Day, Year) AU4176435K17434 06 30. Name and address of pirson who completed cause of death (Item 23a) (Type, Print)

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State

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2006

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31. Date filed (Month, Day, Year)

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BALTIMORE

GREENE ST.

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32. egistrar's Signature

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

NOV 1 4 2006

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 2:30 PM Mary Jean Hertz November 11 D006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The winderful som the If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 3-7-1935 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 1 ☐ M 2 💢 F 71 219-32-7407 Director NĴ Usual Besidence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanians. 10c. City, Town or Location 10b. County 10d. Inside City Limits MDAnne Arundel Glen Burnie 1 ☐Yes 2 X No Funeral Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 327 Ferndale Road 21061 USA 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No white Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Banking 12 computer operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Madeline Ruby Elliott William F. White ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 327 Ferndale Road, Glen Burnie, MD 21061 Mr. Kenneth Hertz/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/15/2006 Stevensville, MD Chesapeake Cremation 22. Name and Address of Facility 21. Signature of Funeral Gervice Lice Singleton Funeral Home P.A. M01364 1 Second Ave SW Glen Burnie MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence f) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 4 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

NOV 1

4 2006

305

32. Registrar's Signature

Dr Suite 305 Glen Burnie

10a. State

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

10

4c. County of Death

**Physician** /Medical **Examiner**  Stephen R. Howard Sr.

10b. County

4b. City, Town, or Location of Death

Timonium

Days

10f. Zin Code

21666

Year 8:53 Ам 2006

**Funeral** 

5. Social Security Number 217-50-9171

Usual Residence of Decedent

Stella Maris Hospice 7. Age (In yrs. last birthday) 1**X** M 2□ F 56 Yrs.

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/4/1949 Hours

Month 11

Baltimore Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 K No

Director

•how r than "naturel", or itema 23a or 28a-f ehov the Medical Examiner must be notified at Director deeth 1 filed within 72 hours after þ Completed other item 27 is marked other other traumatic event, es 1 and 2 should be fill of Health and Mental H Be

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Maryland 21215-0036

Baltimore, NOVEMBER

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Depertment of Important: If any injury or

**Physician** 

Examiner

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signed by the eld be detached for

been

has page 2

certificate

Hospital or Attanding Physician: 24 hours efter death.

Funeral Director: After this certific letely filled in by the funeral director.

2

Division

Exam

Completed by Physician/Medical

Be

Certification: To

Medical

State

Registrar

The law requires that the death certificate be executed

of Vital Records, P.O. Box 68760,

STEPHEN HOWARD

/Medical

10c. City, Town or Location Queen Annes Stevensville

10g. Citizen of What Country?

USA

134 Long Point Road 11. Marital Status

12

10e. Street and Number

12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 3 Widowed 4 Divorced

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No

 Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

self-employed

Security Installation

Melvin Howard

18. Mother's Name (First, Middle, Maiden Sumame)

Mary Rider

19a. Informant's Name/Relationship (Type, Print)

17. Father's Name (First, Middle, Last)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 134 Long Point Road, Stevensville, MD 21666

Mrs. Beverly Howard / wife 20a. Method of Disposition

1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Cremation

20c. Location - City or Town, State 11/15/2006 | Stevensville, MD

21. Signal e of Foreral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

M01364

22. Name and Address of Facility Singleton Funeral Home 1 Second Ave SW Glen Burnie MD 21061

Immèdiate Cause (Final resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

LUNG CANCER Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Day Month

Year

Approximate Interval Between Onset and Death

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

1 Yes 2 No 26. Place of Death | Check only one

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No 27. Manner of Death

1 X Natural

2 Accident

3 Suicide

(Check only one)

5 Pending investigation

6 ☐ Could not be

Hospital:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE 28c. Injury at Work? 1 TYes

28d. Describe how injury occurred 2 □ No

 Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year)

DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year)

2006 NOV 1 4

2300 DULANEY VALLEY RD. 32. Registrar's Signature

TIMONIUM, MD 21093

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_			1 - State Registrar				e of Dea			g. No. U U	6	35948
Я	Physici		Decedent's Name (First, Middle, Last)	_	Have	. ( 0 1/	2		2. Date of Death Month	Day O	Year	3. Time of Death
	/Medi Examir		4a. Facility Name of not institution, give:	street and number)	Harr		Town, or Locat	tion of Death	Novem	4c. County of		1518 PM
			Johns Hopkins	Bayyiew Medi	al Center	_	Saltimo					
	Funeral Director		5. Social Security Number 6. Sec. 15 6. Sec.	7. Age (In yrs	last birthday)	if Under Months	1 Year If Un Days Hou	nder 24 Hrs.	8. Date of Birth (Month, Day, 06/12/	Year)	9. Birthplac Country	(State or Foreign
	0		Usual Residence of Decedent						06/12/	1912 (	OKLAF	IOMA
	darylar	5	MD BALTIMO		ity, Town or Lo		r t m					Inside City Limits 1 ☐ Yes 2 ☑ No
	r 28a-f	rect	10e. Street and Number	KE	LUTHE	10f. Zip			10	g. Citizen of Wh		
	be tiled within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or items 23a or 28a-f show event, the Madical Examinat nast be notified at	Funeral Director	300 WEST SEMINA	RY AVE			21093			USA	at Country	•
	ier dea items	nuel		12. Was Decedent Ever in U	J.S. 13. V	Vas Deced Yes, spec	dent of Hispanic offy Cuban, Mex	c Origin? (Sp xican, Puerto	ecify Yes or No- Rican, etc.)		American White, etc.	
920	urs aft	b	1 ☐ Never Married 2 🕱 Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 ☐ No If Yes, Give Year or Dates: V	ZII. 1	□Yes	2  No Spe	ecify:		Specify:	VHITE	}
50	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Deced	lent's Usua kind of wo	al Occupation rk done during i	most of work	sina 1	6b. Kind of Busi		
121	within ene. then	Jdwo	Elementary/Secondary (0-12)	College (1-4or 5+) YRS	BUSIN	OO NOT us	se retired) INVES			INVEST	TNC	
b	e filed al Hygi other vent,	Be C	17. Father's Name (First, Middle, Last)		120011	1200			e (First, Middle, M			
<u>Ş</u> laı	should be nd Menta marked matic ev	70	GEORGE T. HARRI						THOMAS			
Maryland 21215-0036	Permit. Pages 1 and 2 should Department of Health and Men mportant: if Item 27 is marke ny injury or other traumatic 2008.		19a. Informant's Name/Relationship (Ty) SUSANNAH RIENOF	· · · · · · · · · · · · · · · · · · ·					al Route Number, BALTO			
	item 2		20a. Method of Disposition	20b.	Place of Dispos	sition (Nan	ne of	T .		Oc. Location - Ci		
imo	Page ment o ant: if ury or		1 ☐ Burial 2° 反 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	omoval from State	D ST.	PAUI	LS CHU	RCH 1	1/25/06	BALTO	o. ci	TY, MD.
Baltimore,	permit. Pages Department of I Important: If ite eny injury or of		21. Signature of Funeral Service License		22.	Namean	d Address of Fa	acility	&_SONS			
	11111111111		23a. Part1. Enter the disease, or complic	cations that caused the dea	110	924	YORK	RD_MC	NKTON, N	1D. 211		proximate
	Physician	8 9	shock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on each line.	· · · · ·		,		or respiratory arror	.,	Int	erval Between set and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	The second second second						75	xays
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	cuted nd ransit	mln	Sequentially list conditions. It any, leading to him adiate cause. Enter Underlying Cause (Disease or injury that initiated events	(1)	, 201700 017.							
8760,	ate be executed thysicien and the burial-transit	cal Examiner	resulting in death) Last	Due to (or as a consec	quence of):							
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Records, P.O. Box 6	uires that the death certifica signed by the attending ph d be detached for use as ti	by Physician/Med	200. Was account program	lc. If yes, outcome of pregnant		Ectopic pro				23d. Date o	of delivery	
o B	ne deal the att	/sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of o		Other (sp				Month	Day	Year
<u>ر</u>	Attending Physicien: The law requires that the rideath. ector: After this certificete has been signed by the tuneral director, page 2 should be detached.	y Ph	Part II. Other significant conditions con-	ributing to death but not res	sulting in the un	derlying ca	ause given in Pa	art I.	23e. Did toba	cco use contribu	ute to the ca	use of death?
rds	w requires been sign should be								1 ☐ Yes	1		4 □U⊓known
eco	hes be	Completed							24a. Was an autopsy	24b. We	re autopsy	findings available tion of cause of
	Physicien: The la								performe	ea dea	th? Yes 2	
Ž	ysicie s certi directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 Inpatient 2	ER/Outpatient	3□ DO	Other		n <i>Check only one</i> me 5 ☐ Residen	0 TO:	(0 . ( )	
_ _ _	iding Phith.: After this funeral		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	-	Bc. Injury at Work?		28d. Describe how		(Ѕресіту)	
Division of Vital	or Attendi ifter death. Director: A in by the fu	icati	2 Accident investigation 3 Suicide 6 Could not be	On Blood distance		М	1 ☐ Yes 2					
<u>&gt;</u>	F 8 F C	Certification;	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	y)	et, ractory,	, office		28f. Location (Stre City or Town,	et and Number ( State)	or Rural Ro	ute Number,
	To the Hospitel of within 24 hours af To the Funeral D completely filled in	edlcal C	29a. Certifier 1 Certifying Physical Examin	cian: To the best of my kno	wledge, death	occurred a	at the time, date	and place,	and due to the cau	se(s) and mann	er as stated	
	To the H within 24 To the F complete	Medi	one)  29b. Signature and title of certifier	and manner stated.		-	License numbe					
	F 3 F 8		Parale 1 H	~)						I. Date signed (A		
	10		30. Name and address of person who cor	apleted cause of death (Item	n 23a) (Type, P	rint) _	IE > C		LTIMOR	ONEMINE	1 110	
			Dr. Pamelatto	m 4940	Easter	m F	HVENU	E BA	LTIMOR	E,MD	2130	14
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signa	lture	1						

			1 - For State Registrar	State of Man				lealth a			giene		6	359	)49
0	<b>6</b> , \$.	1 40	1. Decedent's Name (First, Middle, La	nst)						2. Date of De	ath			3. Time o	f Death
ı	Physic /Medi		Edith	S.	Не	enry-	-Wha	len		Month 11	0 <b>7</b>		Year 106	20:4	40 M
	Exami		4a. Facility Name (If not institution, given	ve street and number)		_		Location of	of Death		4c.	County o			
1			Holy Cross Hos					r Sp		3		Mon	tgo	mery	
100	Funeral				n yrs. last birthday, Yrs.	If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	ly, Year)	1	9. Birthp Coun	ace (State try)	or Foreign
*	Director		222-14-7360 Usual Residence of Decedent		7 115.					08 1	0 ]	19		DI	<u> </u>
	/land		10a. State 10b. County	10	Dc. City, Town or L	ocation							1	0d. Inside C	ity Limits
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	th the	lred	10e. Street and Number			10f. Zip					10g. Citi:	en of Wi	nat Coun	try?	
	23a dan	al	12801 Tamarack	Road			20	0904				U.S	. A .		
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Madical Examiner must be notified at	Completed by Funeral Director	11. Marital Status	12. Was Decedent Eve Armed Forces?	or in U.S. 13.	Was Dece	dent of Hi	spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)	)- 1		- Americ	an Indian,	
36	s afte	Y.	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		1 🗆 Yes		Specify:	.,			Specify:			
21215-0036	hour	ed b	Widowed 4 □ Divorced  15. Decedent's E	Year or Dates:	16a. Dece	donte Hay	al Ossuma	t an							
5	in 72 n na Maulic	plet	(Specify only highest gra	ade completed)	(Give	kind of wo DO NOT u	ork done d	lurina mosi	t of workii	ng	16b. Kir	nd of Bus	iness/Ind	lustry	
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b	e file al Hyg othe vent,	BeC	17. Father's Name (First, Middle, Last						r's Name	(First, Middle,	Maiden				
/lai	uld b Ments wrked	ToE	Hurley Henry					Hat	tie	Henry					
Maryland	permit. Pages 1 and 2 should be tited within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any rightry or other traumatic event, the Moulcal Examiner must be notified at Once.		19a. Informant's Name/Relationship (	Type, Print)	19b. Maili	ng Address	s (Street a	ınd Numbe	er or Rura	l Route Numbe	er, City or	Town, S	tate, Zip	Code) 20	904
	and ealth m 27		Sylvia Sandidg					ach 1		d, Sil	ver	Sp	rin		
altimore,	ges 1 t of H if Ite or otl		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo cemetery, crea	matory or c	other place			ate				wn, State	
Ë	tmen tant:		4 Donation 5 □ Other (Specil	۶n S	Siolam C					.4/06	Lin	col	n, l	Delaw	are
Bal	Depariment Department		21. Signature of Funeral Service Licer	1500	22 N	2. Name ar la <b>rc</b> h	Address	s of Facility	st						
- 10	SA TO A		23a. Part1. Enter the disease, or com	Sant To Sayand the	dooth Dood on	300	Waba	ash i	Ave,	Balt	imor	e,	Md	2121	
			shock, or heart failure. List only Immediate Cause (Final	one cause on each line.					cardiac o	r respiratory ar	rest,			Approximat Interval Bet Onset and	ween
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<u>.</u>	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant at time 9□ Unknown	e of death 5 ☐	Other (sp	ecify)					MONIT	1 1	Day \	Year
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	or Attending Physician: Iter death. Director: After this certification by the funeral director.	To Be	examiner? 1 ☐ Yes 2 🗶 No	Hospital: 1 Inpatient	2 ER/Outpatien	t 3 DC	Other			(Check only or ne 5 ☐ Resid			/C		
Division of	ig Phys ter this neral di		27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Time of		8c. Injury	at		8d. Describe h					
ō	Attending death. ctor: After y the funer	atlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation		ar) Injury	м	Work1 1 □ Y	es 2 N	lo						
Ĕ	after deat Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, str	eet, factory	r, office		2	8f. Location (S City or Tow	Street and	Number	or Rural	Route Num	ber,
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·	e Hospital 24 hours a e Funarai I letely filled	cal	(Silver Silv) 2   Medical Exali	ysician: To the best of m	y knowledge, death imination and/or inv	occurred a	at the time	e, date and	place, a	nd due to the o	ause(s) a	ind mann	er as sta	ted.	
	To the Hospital within 24 hours a To the Funarai C completely filled	Medical	one) 29b. Signature and title of certifier	and manner stated.											
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	Y		30. Name and address of person who	¥	•		, ,	E00	T3				, .	0075	
100	Sta	e	Dr. Garg, Kshama 31. Date filed (Month, Day, Year)	32. Registrar's	Signature	pita	1, 1	.500	ror	est Gl	Len	коас	1, 2	0910	
1	Registra		NOV 1 4	UUb Alegare.	1 15 /	Man Car									

State of Maryland / Department of Health and Mental Hygiems () () 5 35950 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year JAMES F. HILL NOV. 07:20a M 10 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2415 BOND RD PARKTON BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 12/31/1926 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1**2** M 2□ F 498-28-4572 Yrs 79 Director MISSOURI Usual Residence of Decedent the Maryland wode 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f ebov other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 🕱 No Director BALTIMORE PARKTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2415 BOND RD USA 21120 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Hem 27 is marked other than "natural", or Itel Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12YRS College (1-4or 5+) CONSTRUCTION CONSTRUCTION WORK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM HILL NAOMI BARTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KEITH B. HILL(SON) 2415 BOND RD PARKTON, MD. 21120. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If itel
any injury or ott 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 MRemoval from State 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEM. 11/14/2006 STATEN ISLAND, N.Y 21. Signature of Funeral Service Licensee 22. Name and Address of Facility W. JENKINS & SONS C YORK RD MONKTON, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC LUNG CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4☐Pregnant at time of death Month Day 5 Other (specify) the Ch 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No this 3 DOA 27. Manney of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 4 hours after death funeral Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Physician Nov. 10th, 2006 MD 050 953-L use of d h (Item 23a) (Type, Print) SURINDER VOHRA M.D. 1600 6th AVE YORK, PA. 17403 31. Date filed (Month, Day, Year) NOV 1 4 2006 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Registrar

P.O.

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 0 6 State State Amend #11 Per Inf g861 11/27 Perificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 7-45 A M JOVEINBER 9 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Itospital Baltimore 21091 Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1XIM 2□ F Director 74 22 1932 MARYLAND 219-28-2769 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 No Director MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 468 OXFORD COURT 21217 Funerai U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours after to Department of Health and Mental Hygiene. Impurtant: If Item 27 is marked other than "naturel", or Item any njury or other treumatic event, the Medical Examinations. Armed Forces:
1 X Yes 2 No
If Yes, Give
Year or Dates: 53/55 1 Never Married XX Married Baltimore, Maryland 21215-0036 Š 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK 3₩Vidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PARKS & RECREATIONS 10th grade LABORER 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) PETE HAZEL CECELIA HAZEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Christine Hazel/Daughter 468 Oxford Ct., Baltimore, Maryland 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 11-14-06 BALTIMORE, MARYLAND 21. Signa Le of Funeral Service License 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner resten 51 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner is a consequence of) to the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Completed 1 Yes 2 No 3 Probably 4 2 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 | Inpatient ٩ 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3区 DOA SIL 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After s after dea... 1 Natural 5 Pending 2 Accident investigation 1 Tes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel C 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Nacom TYTAJUY かナ1 DOLPHIN STREET BALTIMERE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMATUM MUAEM 61 DC 32. Registrar's Signature 31. Date filed (Month, Day, Year) State fresh Registrar A 2006

		ľ	For Stata Registrar		State of N		nd / Depa		nt of H	lealth a				_	6	35953
	Physic /Medi Examir	cal	Decedent's Name (First, M     BEATRICE     4a. Facility Name (If not institute)		treet and numbe	or)			HARR Town, or	ISON Location o	1	2. Date of De Month	R 10		Year 006 of Death	3. Time of Death 11:15 A M
	Funeral Director		GENESIS LAYP 5. Social Security Number 057-03-7013	6. Sex			last birthday)		VER S	SPRING If Under 2 Hours	24 Hrs.	8. Date of Birt 06/30/1	h	NTGC		y place (State or Foreign ntry) NY
	e Maryland te-f show	ctor	Usual Residence of Decedent 10a. State 10b. Cou MD MO		ERY	10c. Ci	ty, Town or Lo	ecation ER SP	RING							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the 23a or 28 Int be no	al Dire	10e. Street and Number 13413 AUTUM	N RIDO	GE LANE			10f. Zip		20906	j		10g. Citi	zen of W	hat Cou	ntry? USA
900	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or iteme 23a or 28e-1 show or other traumatic event, the Madical Examinar must be notified at	d by Funeral Director	11. Marital Status  1 Never Married 2 N  3 Widowed 4 Divor	larried	2. Was Deceder Armed Force 1 ☐ Yes 2 I If Yes, Give Year or Date:	s? X No		Was Deced If Yes, spen		ispanic Origin, Mexican Specify:	gin? (Spec , Puerto P	cify Yes or No- lican, etc.)			k, White,	ean Indian, etc. WHITE
21215-0036	ed within 72 h rgiene. ier than "natu t, the Medical	Completed	(Specify only his	2)	cation completed) College (1-4d	or 5+)	16a. Dece (Give life. STUDE	kind of wo DO NOT u	rk done d se retired	during most ()	of workin	g		nd of Bus		dustry
Maryland	should be filed within ind Mental Hygiene. s marked other than "umatic event, the Max	To Be	17. Father's Name (First, Mide JACOB	ile, Last)			KOLI	S			r's Name .VIA	(First, Middle,	Maiden	Sumame		AMINSKY
_	1 and 2 sho Health and em 27 is m		19a. Informant's Name/Relati				1341	3 AUT	UMN			Route Number				MD 20906
Baltimore	permit. Pages 1 Department of H Important: If Itel any injury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremati 4 ☐ Donation 5 ☐ Othe		amoval from Sta	te C	Place of Dispo cemetery, crei RKMEN	S CIR	other place	1		1		cation - 0	•	own, State
Balt	permit. Pag Department Important: f any injury o		21. Signature of Funeral Serv	ice License	•	,				ERSTU	JUL	LEVINS OAD - F				INC. MD 21208
760,	Physician /Medical Examiner	ical Examiner	23a. Part1. Iter the lease shoot or heart siure. Immedia: Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	, or complicist only on	Due to (or a	DIA as a conseq COR as a conseq	BETES quence of): ONARY quence of):	MELLI	TUS			respiratory ar	rest,			Approximate Interval Between Onset and Death
P.O. Box 68	The law requires that the death centificate be executed as been signed by the attending physicien and a signed a stending physicien and a saga 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23	3c. If yes, outcon 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Feta at time of d	Ideath 3[	Ectopic pr					2	23d. Date Mon		ery Day Year
Records, P.	w requires that been signed b should be deta	by	Part II. Other significant con-		tributing to death	but not res	ulting in the u	nderlying o	ause give	en in Part J.		23e. Did to	,			ne cause of death?
_		e Completed	25. Was case referred to med	ical						20 51	-15	1 ☐ Yes	med? 2 No	de pr	or to co	psy findings available mpletion of cause of
o	ding Phys h. After this funeral di	ToB	examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Per 2 Accident inv	nding estigation	ospital: 1 □ Inpa 28a. Date of In (Month, L		ER/Outpatier 28b. Time o Injury		28c. Injury Work	9r: 4 🔀 Nur	rsing Hom	Check only one 5 Resided.  Bd. Describe h	lence 6			y)
Division	Die	Certification;	4 Homicide det	ild not be ermined		etc. (Specif	(y) 					City or Tow	m, State,			l Route Number,
	To the Hospitel or within 24 hours afta To the Funeral Directional Completely filled in I	Medical	Sile)		ician: To the be er: On the basis and manner	st of my kno of examina stated.	owiedge, death ation and/or in	n occurred vestigation	at the tim , in my op	e, date and pinion, deat	d place, ar h occurre	nd due to the o d at the time, o	cause(s) date and	and man place, a	ner as s nd due to	tated. the cause(s)
	To T To I	Σ	29b. Signature and little of cer	res	u Lu	Me	up		c. License	D5669	91			signed		Day, Year)
	W		DR. GHOUSIA	SULTA	NA 121	LO7 HE	RITAGE		CIF	RCLE -	- SIL	VER SPI	RING	, MD	209	06
37	Sta Regist		31. Date filed (Month, Day, You NOV 1 4		Sz. Hegis	strar's Signa	ature	E A								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Mary Kathleen Johnson 10:10 P<sup>M</sup> November 10. 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 118 North Beechwood Avenue Catonsville Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month) Days | Hours | Min. | Oct 18, 1925 5. Social Security Number . Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 X F 215-22-1557 Maryland 81 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh
any Injury or other traumatic event, the Medical Examiner must be notified;
once. Director Baltimore Catonsville Maryland 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 118 North Beechwood Avenue 21228 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: USA 3

▼ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker OWN Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David E. Barry Katherine M. O'Shaughnessy ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kiaran Johnson - Lew Daughter 24 Ridgefield Street Albany, New York 12208 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory Inc. 11/13/06 Baltimore, Maryland 21. Signature of Funeral Service Lesson
Thomas Gregor 22. Name and Address of Facility Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BREasT **Physician** weeks /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any factor of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No this certificate 1□ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \sum Nursing Home Certification: To 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical ( 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

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Marden

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene For Stete Registre Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** November 10:32P 2006 DORETHA P. JOHNSON /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE'S 5 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 XF 90 579-38-7597 Director JUNE 3 1916 VIRGINIA Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ral', or iteme 23a or 28a-f ehow Examiner must be notified at 1X Yes 2 No MD HOWARD COLUMBIA Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10757 JUDY LANE 21044 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of health and Mental Hygiene.
anti fitem 27 is marked other than "natural", or lies
any or other treumatic event, the Madical Examina 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: À BLACK 3 ☑ Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NURSE PRIVATE vrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be RACHEL BOONE HENRY BURKE SR. ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10757 JUDY LANE COLUMBIA, MARYLAND SHIRLEY THOMAS/DAUGHTER Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of F Important: If ite eny injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State MT. OLIVET CEMETERY 11/13/2006 WASHINGTON, DC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate friterval Between Onset and Death Immediate Cause (Final ARTERIOSCLENT **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. the attending physicien hed for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed þ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 ☐ Yes 2 No 2 FR/Outpatient 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After Certification: 5 Pending Investigation 1 Natural death. м 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 Could not be determined 28e. Pface of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeref [ 29n Curtilia TS Cartifying Physinian: To the best of my knowledge ideath occurred at the time data and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 725206 I anne un 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Covingston Rood Fat WAKHington, mongland - TANNER William My iorli 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ ] [ ] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 422 PM ober 2006 November 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. Birthplace (State or Foreign Country)
 ARYLAN Social Security Number Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Year **Funeral** Days 218-40 Yrs Director Usuat Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ŏ or Items 23a 10 by Funerai Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced "naturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. nemair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Department of Health and Mental h Important if Health and Mental h Important if I tem 27 is meritary or other Be and Mental I IANNA ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zi, Code) 2564 20b. Place of Disposition (Name of cemetery, cremeters Yother homas 20a. Method of Disposition

1 Burial 2 Cremation 3 Pemoval from State
4 Donation 5 Other (Specify) Date 20c. Location - City or Town, State 22. Name and Ad ress of Facility 21. Signature / Funeral Service Licens HILL, MID 21050 23a. Part T. Enter the disease a complications that caused the death shock, or heart failure is only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequenca 37): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that included cause) Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 2 X No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 s autopsy performed? this certificate 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tniury - At home, farm, street, factory, office building, etc. (Specily) 4 | Homicide 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 29c. License number D0053568 2006 Neversber 12

State Registrar 31. Date filed (Month, Day, Year)

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30. Name and address of perso, who completed cause of death (Item 23a) (Type, Print)

32 Aegistrar's Signature

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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#/, DerFH, G861, II/20/06, WS
State of Maryland / Department of Health and Mental Hygiene
Amend #8 Per FH G861 11/17/06

Amend #8 Per FH G861 11/17/06

Amend #8 Per FH G861 11/17/06

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Amend #8 3595 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Norma Jean Johnson November 12, 2006 3:55 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Assisted Living Towson **Baltimore** If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Ohio 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeal 938 **Funeral** Days Hours 1 M 2 K F  $\frac{-76}{}$  68 Yrs. 212 36 2765 28, Director 1930 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at Maryland 1X Yes 2 No Director N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5721 Edmondson Avenue 21228 U.S. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Clerica1 State of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grover Deavers Doris Sharps 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Johnson / Son 1223 Wild Turkey Court Jacksonville, Florida 32259 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 □Removal from State 11/16/2006 | Baltimore, Maryland Holy Cross Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 90 Physician Cancer 40005 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) WUSOLO Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 November 13 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Agran Charles 7 Charle St Tower MD 21254 6564 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 4 2006 1 Albert Registrar

			, roi	partment of Health and Mental Hygiene ertificate of Death
ı	Physici		1. Decedent's Name (First, Middle, Last) Jessie	Klimm 2. Date of Death Month Day Year November 9, 2006 2:25 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Riverview Nursing Home	4b. City, Town, or Location of Death Essex    Accounty of Death   Baltimore Co.
	Funeral Director		5. Social Security Number  216-24-4747  Usual Residence of Decedent	Months Days I Hours Min. (Month. Day, Year) Country)
13-0030	naturel', or ite dicai Examina	Completed by Funeral Director	1 Never Married 2 Married 1 Yes 2 No H Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. De (Gift)	Dundalk  10d. Inside City Limits 1 □ Yes 2 ☒ No  10f. Zip Code 10g. Citizen of What Country? United States  3. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes 2☒ No Specify:  Specify:  White  cedent's Usual Occupation we kind of work done during most of working 3. DO NOT use retired)
Haria 6 161	ental Hygiene. Ked other than ic event, the M	To Be Comp	Elementary/Secondary (0-12)   College (1-4or 5+)	Iomemaker  Own Home  18. Mother's Name (First, Middle, Maiden Sumame) Ukn.  Eva
e, maryia	ealth and Me m 27 is mark	ř	19a. Informant's Name/Relationship (Type, Print)  Jerome Klimm, Jr. (Son)  19b. Ma	ailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Of Fenway Dundalk, Maryland 21222
	Department of Hi Important: If Iter eny injury or oth once.		1X Burial 2 Cremation 3 Removal from State	position (Name of rematory or other place)  Date 20c. Location - City or Town, State 20c. Location - City or Town, State 22c. Name and Address of Facility 22c. Name and Address
			23a. Part1. Enjer the disease, or complications that caused the death. Do not shock, of heart failure. List only one cause on each line.	22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc.  7922 Wise Ave. Dundalk, Maryland 21222  enter the mode of dying, such as cardiac or respiratory arrest, Interval Between
be executed	hysician and publication and the prizer-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	ed Lung Tumor in Kurun
The law requires that the death confliction	ed by the attending pl	Physician/Me		3 Dectopic pregnancy 23d. Date of delivery 5 Other (specify) Month Day Year
cords, F.	been signed by	Ď	Part II. Other significant conditions contributing to death but not resulting in the HTM, Anemia, C, Advanced Demontia	PRD 1 Yes 2 No 3 Probably 4 Honknown
	s certificate has t lirector, page 2 s	e Completed	25. Was case referred to medical	24a. Was an autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No  26. Place of Death (Check only one)
5 8	⊈ es	atlon: To B	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat  27. Manner of Death 1 Adtural 5 Pending (Month, Day Year) 2 Accident investigation	tient 3 DOA Other. 4 Nursing Home 5 Residence 6 Other (Specify)  e of 28c. Injury at 28d. Describe how injury occurred
	within 24 hours after death.  To the Funeral Director: After or mpletely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	City or Town, State)
i ode	thin 24 ho the Fune mpletely fi	Medical	29a. Certifier     (Check only one)  2    Medical Examiner: On the best of my knowledge, de (Check only one)  2    Medical Examiner: On the basis of examination and/or and manner stated.  29b. Signature and title of tertifier	path occurred at the time, date and place, and due to the cause(s) and manner as stated investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  29c. License number  29d. Date signed (Month, Day, Year)
1	2 4 6		30. Name and address of person who completed cause of death (Item 23a) (Type	D-38754 11-09-2006
5	Sta	ate	MALIKA WAS BLM. 700,  31. Date filed (Month, Day, Year).  32. Registrar's Signature	EASTERN BLUD - MD - 21221
	Regist		NOV 1 / 2006	Land.

ORIGINAL

			1 - For State Registrar		Maryland		artmen rtificate			ind N		giene Reg. No.	2006	35959
	Physic /Medi		Decedent's Name (First, Middle, L     Peter Lugo								2. Date of De Month NOVEM	Day	Year 200	3. Time of Death
	Examii Funeral	ner		NOSPI	TAL Age (In yrs. last	birthday)	G If Under	AL- 1 Year	Location o	0 R 2 24 Hrs.	8. Date of Bir	th	N/A  9. Birt	halon (Chata a Fari
	Director		216-60-5418  Usuaf Residence of Decedent  10a. State 10b. County	1XM 2□ F	54	Yrs.	Months	Days	Hours	Min.	MAR 5,	1952	Co	dermany  10d. Inside City Limits
	ith with the Marylar 23s or 28s-f show	Director	MD Anne Aru  10e. Street and Number	ndel.		Bur		Code				10g. Citiz	en of What Co	1 □ Yes 2X No
920	after dea or itsms	by Funeral	312 Lori Dr Apt F	12. Was Decede Amed Force 1 Yes 2! If Yes, Give Year or Date	s? No	ì		_	spanic Orig n, Mexican, Specify:	in? (Sp. Puerto	ecify Yes or No Rican, etc.)		4. Race - Ame Black, White Specify: Whi	e, etc.
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours I Health and Mental Hygiene Item 27 is marked other then "natursi", other traumatic event, the Medical Exp	Completed	15. Decedent's 8 (Specify only highest gi Elementary/Secondary (0-12) 12			(Give life.	dent's Usua kind of wor DO NOT us uffeul	k done d e retired,	urina most	of work	ing		d of Business/	
ryland	should be filed nd Mental Hygid marked other Imatic event, II	To Be (	17. Father's Name (First, Middle, Las Neptali Lugo						Jose	phir	e (First, Middle, ne Kraus	Maiden S	Gu <i>rnam</i> e)	
Baltimore, Mai	permit. Pages 1 and 2 sho Department of Health and Important: If Item 27 is mu any injury or other traumang.		19a Informant's Name/Relationship Robert Lu. o/Broth 20a. Method of Disposition 1	er  Removal from Sta  fy)  nseeC. Todd	te 20b. Place ceme Metro	308 a of Dispositery, cree c Cre	8th And sition (Name and or other and or other and or other and or other and or other and or other and or other and or other and other a	Ave the of the place y, I Address	S.E. (	Gler	of Maryl	e, MD 20c. Loc Balti	21061 ation - City or Limore,	Town, State
8760,	Physician /Medical Examiner	licai Examiner	23a. Part1. Enter the disease, of con shock, or heart failure. List enty fmmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. META Due to (or a Due to (or a	sed the death. If ine.  STATI as a consequence as a conse	ce of):	COLC	of dying REC	ZAL	eardiac c	CARCI			Approximate Interval Between Onset and Death 2 MONTA
O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physicien and age 2 should be detached for use as the burial-transit	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death	ath 3□	Ectopic pre					23	d. Date of delin	very Day Year
ords, P.	w requires that been signed b should be det	by	Part II. Other significant conditions	contributing to death	but not resulting	g in the u	nderlying ca	use give	n in Part I.			bacco use		the cause of death?
of Vital Records,	0 L	e Completed	25. Was case referred to medical								100	med?	24b. Were aut prior to c death? 1 ☐ Yes	opsy findings available ompfetion of cause of
Division of Vi	tending Phye leath. tor: After this the funeral di	Certification; To B	examiner?  1 Yes 250 No  27. Manner of Death  5 Pending  2 Accident investigatio  3 Suicide 6 Could not be		njury 28t Da <i>y Year)</i>	. Time of Injury	28 M	c. Injury Work?	4 Nurs	sing Hor	Check only or ne 5 Resid 28d. Describe h	ence 6 (		ufy)
Divi	in the qu		4 Homicide determined	building,	njury - At home, etc. (Specify)	lge, death	occurred a	t the time	a, date and	olace a	City or Tow	n, State)	nd manage as	ral Route Number,
	To the Hospital within 24 hours a To the Funeral t completely filled	Medicai	(Check only one) 2 Medical Example Medical Example 29b. Signature and title of certifier	miner: On the basis and manner	of examination	and/or inv	estigation, i	License	nion, death	occurre	ed at the time, o	late and p	lace, and due	to the cause(s)
•	10		30. Name and address of person who		death (ftem 23a	a) (Type, I		12	189	DA	171M=	NOV	4,	2006
	Sta Registr		31. Date filed (Month, Day, Year)	32. Rogis	trar's Signature	CHI	UIV	AV	C ;	יוכו	C(1110	12	,141)/	21229

DHMH 17 Rev 1/2001

LUGO, PETER

			1- State Registrar  Amend Items 2013,20,127 and Descriment P4/00 in Fill Description of Death	ind Me	ental Hygie	ne No. 20	06	35960	0
		-	Decedent's Name (First, Middle, Last)		2. Date of Death			3. Time of Death	٦
П	Physicia	an			Month	Day	Year	7.20 A M	
	/Medic	al	JANIE LITTLE		OVEMBER	3, 20 4c. County		7:30 A M	$\dashv$
X	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of	Deam		4c. County	oi Dealii		-
Q.			2105 PENROSE AVENUE 5 Social Security Number 6 Sex 7 Age (In vrs. last birthday) If Under 1 Year If Under 2	74 Hrs. 1 6			o D: 11	(2)	_
	Funeral		Months Days Hours	Min. 8	(Month, Day, Ye		9. Birthpi	lace (State or Foreign try)	
	Director		219-40-9718 62		12-26-1	943		MD	_
	pu »		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10	0d. Inside City Limits	
	anyla shov d at	_						1X Yes 2 □ No	
	Ba-f	ctc	MD BALTIMORE						_
	ith th	Director	10e. Street and Number 10f. Zip Code		10g.	Citizen of W	rnat Coun	try ?	
	ours after death with the Marylan ral", or Items 23a or 28a-f show Examiner must be notifiled at		2105 PENROSE AVENUE 21223			US			
	dea ems	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican,	gin? (Speci , Puerto Ri	ify Yes or No- ican, etc.)		e - America k, White, o		
ထ္	or It		1 ∏X Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☒ No Specify:			Specify			
ဋ	ours ral", Exa	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			' '	BLA		
21215-0036	i 72 hours after dea "natural", or Items edi: al Examiner mu	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most	t of working		b. Kind of Bu	siness/Ind	dustry	
7	thin Ian " Me	ğ	Elementary/Secondary (0-12) College (1-4or 5+)						
7	filed wi Hygien ther th	Ö	2 LICENSED PRACTICAL			HEAI		<del></del>	4
b	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be (	17. Father's Name (First, Middle, Last)	r's Name (i	First, Middle, Mai	iden Surnam	e)		
<u>a</u>	Aent Ment rked ric e	2	JOHN HENRY LITTLE REF	BECCA	PEAY				
Maryland	2 should and Mer Is marke aumatic		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number	er or Rural I	Route Number, C	ity or Town,	State, Zip	Code)	
	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygleine. Important: If Item 27 Is marked other than "natuu any Injury or other traumatic event, the Medical once.		MARGARET WILSON/SISTER 2114 PARK AVENUE	BALT	IMORE, M	D 212	217		
Baltimore,	f He		20a. Method of Disposition  20b. Place of Disposition (Name of	Dat	te 20	c. Location -	City or To	wn, State	
2	Pages nent of int; If its iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	11-14	4-06 B	ALTIMO	ו שמ	MTD	
⋣	it. Partme		21. Signatore of Funeral Service Licensee 22. Name and Address of Facility						$\exists$
Ba	permit. Departr Importa any Inji		1701-31 LAURENS		BALTIM			1217	
	20200		70170				נ א	Approximate	-
			23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a shock, or heart failure. List only one cause in each line.	cardiac or	respiratory arrest	2		Interval Between Onset and Death	
1	Physician		Immediate Cause (Final disease or condition						
7	/Medical		resulting in death)  Due (or as a conse uence of):					1	
18	Examiner		Sequentially list conditions b. HyDEV TENSION			20.00		Hear	
	4	Je	Sequentially list conditions, and any leading to inneution cause. Enter Underlying	_					
	be executed ician and burial-transit	Examiner	Cause (Disease or Injury that initiated events	ne.	<u> </u>				
Ć	execting and rial-tr	EX	resulting in death) Last  Due to (or as a consequence of):						
760,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	ca	a Anxiety 1 Jedression					1	
.89	ficat p phy s the							V	
×	death certifica e attending ph d for use as th	Physician/Med	IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Dat	e of delive	ery	
Вох	atter for u	ciar	in the past 12 months?			Mo	nth	Day Year	
o.	the d	ysi	1 Yes 2 No 9 Unknown 9 Unknown						
<u>α</u>	requires that the leen signed by the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobac	cco use conti	ribute to th	ne cause of death?	
ds,	signe signe	b o	Nouvaminy		1 ☐ Yes	2 <b>V</b> No	3 ☐ Prob	ably 4 Unknown	
Division of Vital Records,	een	Completed by	1 more in						_
ပ္မ	The law ate has b	ple			24a. Was an autopsy		prior to co	psy findings available mpletion of cause of	
<u> </u>		Ю			performe 1 Yes 2 €	No 1	death? I □ Yes	2 No	
ta	Attending Physician: r death. ector: After this certific. by the funeral director,	Be (	25. Was case referred to medical examiner?	of Death (	(Check only one)				
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0	g Ph er th		27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?	28	3d. Describe how	injury occurr	ed		
0	ndin tth. r: Af	엹	1X Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident intestigation M 1 ☐ Yes 2 ☐ N	No					
NIS.	Atte r deg ecto by th	Certification:	3 ☐ Suicide 4 ☐ Homicide  3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide	28	Bf. Location (Stree City or Town, S	et and Numb	er or Rura	I Route Number,	
Ď	afte Dir	ert	a Duilding, etc. (Specify)		Only or Young	Siare)			
)	Hospital 4 hours a Funeral I tely filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date an	nd place, ar	nd due to the cau	se(s) and ma	nner as s	tated.	
	24 h	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dea and manner stated.	ath occurre	d at the time, date	e and place,	and due to	o the cause(s)	
	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Me	29b. Signature and title of certifier 29c. License number		29d	. Date signe	d (Month,	Day, Year)	_
	F S F Ö		M.D. Irrian	97	2	112	01		
,	(1)		, ous of the state	10	0	1110	V4		_
(	Al		30. Name and address of person who sampleted cause of death (Item 23a) (Type, Print)	WO.	1501 t	11.03	2	St Ral	1
			31. Date filed (Month, Day, Year) 82. Registrar Signature	Ut	12/1	MA	ULL	01.11	1
		ate	31. Date filed (Month, Day, Year)  NOV 1 4 2006					MI	ン
	Regist	Idi							

				State of Maryland / D	Department of Health and		
			1 - For State Registrar		Certificate of Death	Reg. 7	71116 35961
	Physici	an	1. Decedent's Name (First, Middle, Last	1		2. Date of Death	3. Time of Death
	/Medi	cal	Marie W.	Lewis .		Nov. 10	0, 2006 H: 30 PM
	Examir	ner	4a. Facility Name (If not institution, give	2 11.1	4b. City, Town, or Location of Dea		4c. County of Death
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs. last birt	hday) If Under 1 Year If Under 24 Hr	S. 8. Date of Birth	9. Birthplace (State or Foreign
	Director		012-96-6160	M 20 F 91	Yrs. Months Days Hours Mir	08-10-19	15 Country) MD
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
	Mary Mary	tor	MD .	Bal-	fimore		1 Nes 2 No
	or 28	Director	10e. Street and Number	1 1 7	10f. Zip Code	10g. (	Citizen of What Country?
	sath w	erai	2808 Hucher	Horoly Herrac	e 21217		USA
<b>'</b> 0	r Item	Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent/Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No	13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036	hours after death with the Maryland tural, or Items 23a or 28e-f show al Examinar must be notified at	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Black
15-(	"natu	Completed	15. Decedent's Edu (Specify only highest grad	cation 16a. e completed)	Decedent's Usual Occupation (Give kind of work done during most of we life. DO NOT use retired)	orking 16b.	Kind of Business/Industry
12	within jene.	отр	Elementary/Secondary (0-12)	Reliege (1-4or 5+)	leck	$\mathcal{L}_{\mathcal{L}}$	rial Society
	be filed tal Hygi d other	BeC	17. Father's Name (First, Middle, Last)	- CYYO		me (First, Middle, Maid	en Sumame)
ylaı	ould b Menta arked	To	Thomas Wiks	00	Flore	a Nichol	S
Maryland	s 1 end 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28e-1 show other traumatic event, the Medical Examinar must be notified at	-	9a. Informant's Name/Relationship (T)	pe, Print) 615 1 57	Mailin Adress (Street and Number of	- 1.	11 114 1,701
-	Heali Heali tem 2		20a. Method of Disposition	20h. Place of	Disposition (I ame of		Location - City or Town, State
Ë	Pages nent of int: If i		1 Surial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Crematory frother place)	16,200 A	rhutus M8
Baltimore	permit. Pages Depertment of H Important: If ite any injury or of		21. Signature of Fundral Service Licens	(0)	22 Ame and Address Cacilla	cene Fun	eral Services
ш	20519	9	Vaugn C.	There	8728 Liberty Ro	1. Randall	1stown, mD 21133
			shock, or heart failure. List only of the complete the control of	ne cause on each line.	ot enter the mode of dying, such as cardia	ic or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence o	hal Infact	ξη	
н	Examiner		Sequentially list conditions	Coror	ion Artin	elines	×
7	be sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	():		
	w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	xan	that initiated events resulting in death) Last	Due to (or as a consequence of	f):		
760,	ysicier	cal	L.	1.			
89	ntifica ing ph	Med	IF FEMALE:				
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 Ectopic pregnancy		23d. Date of delivery  Month Day Year
o	the de	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5 Other (specify)		
o. O.	s that pned b	by Pl	Part II. Other significant conditions con	tributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
g	equire sen siç ould b	ted !	Chronic	Kenai fail	we	1 ☐ Yes	2 No 3 Probably 4 Unknown
Sec.	B law I has b	Completed	Ahisi	phallactin		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
<u>a</u>	n: Th ficete rr, pag		Deep vene	In thromi		performed? 1 ☐ Yes 2 ☑ N	death?
5	ysicie s certi	To Be	25. Was case referred to medical examiner?	lospital:		ath (Check only one) Home 5 Residence	6 Dotton (Grant)
- -	ng Phy ter thi neral		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury 28b. Til		28d. Describe how inj	
Sio	ttendii deeth. stor: A	catio	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No		
Division of Vital Record	after of Direction by	Certification;	4 Homicide determined	28e. Place of Injury - At home, farr building, etc. (Specify)	m, street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospital or Attending Physicien: The law requires that the death certifics within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.		29a. Certifier 1 Certifying Physic (Check only 2 Medical Exami	ician: To the best of my knowledge,	death occurred at the time, date and place	e, and due to the cause(	s) and manner as stated.
	the H nin 24 the Fi nplete	Medicai	one)	and manner stated.	or investigation, in my opinion, death occi	urred at the time, date ar	nd place, and due to the cause(s)
	S iš C o	~	29b. Signature and title of certifier	22 2	29c. License number	29d. D	ate signed (Month, Day, Year)
•	Q	-	30. Name and address of person who co	tropleted cause of death (Item 23a) (T	2006 14:	1)   (	113/06
_	0		SCSANTA ADET	,		AVENJE . P.	BAZTIMORE, MD 21215
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	DO LIBERTY HET		
	Registr	ell.	NOV 1 4 2006	Sale of the sale of			

			For State Registrar		aryland / D	Departme	nt of Health	and Me	_		gible.		
			Registrar  1. Decedent's Name (First, Middle, La.	-41		Certifica	te of Death		Re 2. Date of Deat	g. No.	UU.5	35962	_
	Physici /Medic	-	MICHAEL	LEE					Month	1 <sup>D</sup> 2 <sup>y</sup>	2006	3. Time of Death  2. 49 Am	
Cont.	Examin	er	4a. Facility Name (If not institution, give				, Town, or Location	of Death		4c. Co	ounty of Death		
			Genesis - Mult				Towson	r 24 Hrs.   g	18:11		Baltin		_
Ė	Funeral Director		5. Social Security Number  213-68-4471  Usual Residence of Decedent	ex 7. Age	e (In yrs. last birt	Yrs. Months		Min.	B. Date of Birth (Month, Day, 0/22/1	954	9. Birth Cou Mai	place (State or Foreign ntry) yland	
	yland yland		10a. State 10b. County		10c. City, Town	n or Location						10d. Inside City Limits	-
	death with the Maryland ime 23a or 28a-f show	Funeral Director	MD Balti	more	more Baltimore							1 □ Yes 2□No	
	with with	늅	10e. Street and Number 4413 Ridge Dr.			101. 2	ip Code 21229		1	og. Citizer	of What Cou	ntry?	
	me 23	era	11. Marital Status	12. Was Decedent I	Ever in U.S.	13. Was Dec		rigin? (Speci	ify Yes or No-	14.	USA Race - Amen	can Indian,	_
	iges 1 and 2 should be filed within 72 hours after death with the Marylar to Health and Menial Hygiene. If Item 27 is marked other than "naturel, or lieme 23a or 28a-f show or other treumatic event, the Madical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 2 ☐ Married	Armed Forces?  1 Yes XIX  If Yes, Give Year or Dates:	No	If Yes, sp 1 ☐ Yes	edent of Hispanic Or ecify Cuban, Mexica 2 No Specify		ićan, etc.)		Black, White,		
ည်	72 ho	Completed	15. Decedent's En (Specify only highest gra		16a.	Decedent's Us	ual Occupation rork done during mos use retired)	et of working			of Business/Ir	,	-
7	ithin Ma	npie	Elementary/Secondary (0-12)	College (1-4or 5	i+)				<b>'</b>			ty of	
N	filed w Hygier ther th	်	10			Polic	e Office				ryland	l	
Maryland	ould be fi Mental H arked ott	To Be	17. Father's Name (First, Middle, Last, Robert L. Le						First, Middle, M Margue			ert	
Mar	nd 2 shoulth and 27 ie m		19a. Informant's Name/Relationship ( Bonnie A. Leas	**			ss (Street and Numb Ridge Dr						
ē,	ttem item		20a. Method of Disposition		20b. Place of	Disposition (A)	ama of	Da	to T	-	tion - City or T		1
Ē	Page nent on int: If		1 🖾 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		More.	land, M	emorial	15,	2006	Pai	rkvill	e.MD	
Baltimore,	permit. Departricular porta		21. Signature of Funeral Service Lice	isee . I l			Address of Faculture Funeral remaction			Par	0 Har	ford Ed,	
	PALS.		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do r					est,		Approximate Interval Between	
pe	Physician		Immediate Cause (Final disease or condition	Des	tic	sho	-10					Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):	481-					001-1	
	٠ = و	ner	Exquariting hist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequent a of :								70075	
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. / h &	a consequence			トクレナンナン					
760,	be executionand initial-transfer	cai E	rosaling in osalin, cast	180	1			YONTHS					
687	# × ®	edic		d	8	7						/-/-//2	-
Вох	death certificat ie attending phy od for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome 1□Live birth 4□Pregnant at	2 Fetal death	3 □Ectopic 5 □ Other (				230	d. Date of delive	ery Day Year	
o.	by th	hys	9 Unknown	9□ Unknown									
S, D	res tha igned be del	by P	Part II. Other significant conditions		ut not resulting in	n the underlying	cause given in Part	1.	23e. Did tol	acco use	contribute to	he cause of death?	1
2rd	w require been si should I	ed	Theumor	na					1 □ Ye	es 2 🗆 N	No 3□Pro	bably 4 Unknown	Į
Vital Records,	a 2 0	Completed							24a. Was a autops	v	24b. Were aut	opsy findings available ompletion of cause of	
<u> </u>		် ပ							perform	ned? 2 No	death? 1 ☐ Yes		
Vita	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			1 -	ce of Death (	Check only on	Θ)			_
	Phys this aldii	2	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie		tpatient 3 🗍 [			e 5 Reside			(y)	
O	ding h. After fune	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Da	y Year)	njury M	28c. Injury at Work? 1 ☐ Yes 2 ☐		ld. Describe ho	w injury o	ccurrea		
Division of	at or Attending after death. I Director: After d in by the funer	Certification:	3 Suicide 6 Could not b		ury - At home, fa c. (Specify)				If Location (St City or Town	reet and ^ n, State)	vumber or Rur	al Route Number,	1
	Hospita 24 hours Funere	edicai C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	nysician: To the best niner: On the basis of and manner sta	f examination an	e, death occurre	d at the time, date a on, in my opinion, de	and place, an	d due to the ca	ause(s) an ate and pla	nd manner as a	stated. o the cause(s)	
	To the within To the comple	Me	29b. Signature and title of certifier			2	9c. License number				signed (Month,		
	3		> F. 15e. Go	Lo Me	20		0327	17		11/1	3/20	006	
	10		30. Name and address of person who	completed cause of d	leath (Item 23a)	(Type, Print)	10 WSO	Nos	ME	2	2/22	14	
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	CONSIL							

			1- For Amend #17 &18	State of Marylan Per FH G861 1	d/Depa 1/15/0	rtment of H	lealth and M Death	lental Hy	giene Reg. No. 0	6 35963
	Physicia	an	1. Decedent's Name (First, Middle, Last, Clara Amelia Gift				2. Date of De. Month NOV . 9	Day V	ar 1.0 0.0 A M	
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	NOV. 9	\$ 2006 . 4c. County of	10:00 A M
		Joseph Richey Hospice					re		N/A	
	Funeral Director		EEE OE EOII	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da 4/14/19	912	D. Birthplace (State or Foreign Country) PA
	yland		Usual Residence of Decedent  10a, State 10b, County		r, Town or Lo	cation				10d. Inside City Limits
	Ba-f et	ctor	MD Baltim	ore Di	ındalk					1 □ Yes 2 <b>X</b> No
	23a or 24	al Dire	410 Wise Ave.			10f. Zip Code 21222			10g. Citizen of What	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 ie marked other then "naturel", or Items 23a or 28a-f show eny Injury or other traumatic event, the Medical Examinar must be codified at once.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 🕱 No tf Yes, Give Year or Dates:	'	Was Decedent of Hi f Yes, specify Cuba 1 □ Yes 2🛣 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Black,	American Indian, White, etc. White
5.0	72 ho 'natur	eted	15. Decedent's Edu (Specify only highest grad		(Give	ient's Usual Occupa	during most of work	ing	16b. Kind of Busin	ness/Industry
21215-0036	within ene. then '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. i	COOK	0		Univers	ity
Maryland 2	ld be filed ental Hygi ked other Ic event,	To Be Co	17. Father's Name (First, Middle: 125) Elmer Nolan Cook				18. Mother's Nam Clara	May Middle,	Maiden Sumame) *CaW	
lary	2 shou and M le mar aumat		19a. Informant's Name/Relationship (T)		4				er, City or Town, St	ate, Zip Code)
	1 and Health em 27 sther tr		Mrs. Ruth Ann Cope / I	20b. P	lace of Dispo	Wise Av		Date	MD 21222 20c. Location - Ci	tv or Town. State
POE	Pages nent of int: If it		1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State	emetery, crer	natory or other plac OCK Cem.	11/11	/2006	Wilmingto	
Baltimore,	permit. Depertm Imports eny Inju		21. Signature of Funeral Service Licens	•• Kimberly David	SOi1 22	Name and Address	J. Ruck,		5305 Harfo Baltimore	ord Rd. , MD 21214
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	lications that caused the death	. Do not ent					Approximate Interval Between
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a CONGO	13/1	re nu	JIT J	W/4	111	2/1/5
	Examiner		Conversion line and divine	Due to (or as a ffinseque	Jence of):					
	sit	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ						
Ć.	licate be executed physicien and s the burial-transit	Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):							
8760,	ate be hysicie the bur	dical	(	d						4
.O. Box 6	of the death certific by the attending p tached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregna 1□Live birth 2□Fetal 4□Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	
<u>α</u>	es the gned be de	by	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the u	nderlying cause give	en in Part I.			ute to the cause of death?
Records,	halaw e has b aga 2 sl	Completed						24a. Was autor perfo 1  Yes	psy prio	ire autopsy findings available or to completion of cause of ath?
Vital	Physician: T this certificat ral director, pa	Bec	25. Was case referred to edical examiner?	UA-L			26. Place of Deat			Harris
of		To To	1 ☐ Yes 2 ☐ M6 27. Manny of Death	28a. Date of Injury	ER/Outpatier 28b. Time o		4 □ Nursing H	ome 5 Resident	dence 6 // ther	11 10 11
ion	Attending I r death. ector: After by the funer	atlor	1 2 atural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		k? Yes 2 □ No			/
Division	l or Atten eftar deat Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specify		eet, factory, office		28f. Location ( City or To		or Rural Route Number,
	Hospita 4 hours Funeral	edical C	29a. Certifier 1 Certifying Phy (Check only one)	vsician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, deat tion and/or in	n occurred at the tim vestigation, in my of	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and mann date and place, and	ner as stated. d due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	Polled	IM	29c. License	e number		29d. Date signed (	Month Day, Year)
	12		30. Name and address of serson who c	ompleted sause of death (Item	12aa) (Type,	Print)	1012	Bri	111/1/	10000
	Sta	10	31. Date filed (Month, Day, Year)*	32. Registrar's Signa	MILL	WUW	19	001	0,114	14/4/9
	Regist		24.00	06 Aren	K A	with	•			

10:00 am

11/9/06

Clara Larkin

-00443		Please Type or Print in Black indelible ink			
in W. Louderr		State of Maryland / Department of Health and Mental Hy	/giene	200	2000
		1- For State Certificate of Death	R	eg No ZUU	5 3596
Physicia		1. Decedent's Name (First, Middle,Last)	2. Date of Dea	ith	3. Time of Death
edical Exami	ner	Alvin W. Loudermilk	Month Novembe	Day Year	2000 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	HOVEITIBE	4c. County of Death	
		Franklin Square Hospital Rosedale		Baltimore Cou	
			To 0		•
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	-	rth(MM/DD/YYYY) 9 Bir Foreig	ın
Director		219-60-5967   1X M 2 F   56 Yrs   18	April	L 23,1950 co	untryMaryland
		Usual Residence of Decedent	<u> </u>		
any		10a. State 10b. County 10c. City, Town or Location			10d Inside City Limits
how.		Maryland Baltimore Middle River			1 Yes 2 X No
rylar a-f s	윉	10e Street and Number 10f. Zip Code	11	log. Citizen of What Coul	ntry?
ith the Maryland 23a or 28a-f show any notified at once.	Director	1016 Meadow Glen Road 21220		TT '1 3 G1 1	
th th 23a notif			:E \/ N-	United Stat	
eath wi	uneral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 3. Was Decedent of Hispanic Origin? (Sp. 1f Yes, specify Cuban, Mexican, Puerto		74. Race - Amer White, etc.	can Indian, Black,
r death or iter	흾	1 Yes 2 X No .		7,	hite
after al", iner	2	3 Widowed 4 X Divorced If Yes, Give Year or Dates:		Specify	
ours	豆	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retir		16b. Kind of Business/	ndustry
72 h	ӭ	Elementary/Secondary (0-12) College (1-4 or 5+)	ouj	Road	
O36 ithin ne. rha	릵	12 Years Road Contruction		Mainter	nance
ed w lygre other	Completed	17. Father's Name (First, Middle, Last) 18.Mother's Name	(First, Middle,	Maiden Surname)	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	ä	Glen Edward Loudermilk	Nancy	/ Jane Varne	2V
Men Men C eve	٥	19a. Informant's Name/Relationship (Type, Print )  19b Mailing Address (Street and Number or R	tural Route Nur	mber, City or Town, State	, Zip Code)
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Heath and Mental Hygiene. unt: If item 27 is marked other than "natural", or items 23a or 28a-f shorr other traumatic event, the Medical Examiner must be notified at once.		Wesley Loudermilk, Jr. (Son) 206 Ashwood Road Ba	1timore	e, Maryland	21222
and and lealth tem		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or	
Or Fire ther		1 X Burial 2 Cremation 3 Removal from State crematory or other place)			
Pag ment tant:			/10/200	)6 Middle	River, MD
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	Homo o	of Dundalk	Ing
ш жав.в	d	Duda-Ruck Funeral 7922 Wise Ave. I	Dundalk	, Maryland	Inc. 21222
Physician		23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line.	respiratory arr	rest, shock, or heart	Approximate Interval Between Onset and
/Medical		Immediate Cause (Final disease a. Hypothermia complicating cirrhosis of liver ar	nd acute	alcohol intoxi	ul
Examiner		or condition resulting in death)  Due to (or as a consequence of)			
		Sequentially list conditions, b			
	ē	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
	Ē	(Disease or injury that initiated			
red	Examiner	events resulting in death) Last  Due to (or as a consequence or):  d.			
ires that the death certificate be executed signed by the attending physician and be detached for use as the burial - transi	dical	LINDENDED			
0, be e	edi	#Z3a,2/,28a=I,per ME, (86), 1////06 1	T		
Records, P.O. Box 68760, The law requires that the death certificate be sate has been signed by the attending physici rage 2 should be detached for use as the burings	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnance	nev	23d Date of delivery  Month	oay Year
68 certii nding	iar	past 12 months?	ricy	WOTEN	Jay Teal
OX eath for u	Sic	1 Yes 2 No 9 Unknown			
the d	F.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did to	obacco use contribute to	the cause of death?
P.O.	Š			s 2 V No 3 Prob	-
S, F uires n sig	eq				,
ords A requir	je		24a Was autor		topsy findings available completion of cause of
e lav	Completed		perfo	ormed? death?	es 2 No
		25 Was case referred to medical 26 Place of Death (Check of Death Check		2 110	
Vital Rec ssician: The his certificate director, page	Be	examiner? Hospital: 1 Inaction 2 FR/Outpotion 3 DOA Other Nursin	g Home 5	Residence 6 Other	
of Vital Records ing Physician: The law requ After this certificate has been uneral director, page 2 should	٩	1 ✓ Yes 2 No Impater 2 ✓ ENOutpater 3 DOA 4 Normal		how injury occurred	- <u>-</u>
n of ling Ph After 1	Ë	1 Natural 5 D 2 (Month, Day, Year)	200. Describe	now injury occurred	
ttene death rtor:	aţi	Natural 5 Pending Fnd 11/6/2006 Fnd 6:22 pm 1 Yes 2 X No		n cold environ	
Division of Vital Records, and or attending Physician: The law requires after death all Director: After this certificate has been siled in by the funeral director, page 2 should be	ij	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (	Street and Number or Ru State) Rossville	ral Route Number, City
pital Di	Certification:	determined a	Rosedale	MD Yellowbro	ok Road
Hosp 24 hc Fund tely f		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	due to the caus	se(s) and manner as star	ted
Division of Vital R To the Hospital or Attending Physiciau: within 24 hours after death To the Funeral Director: After this certificompletely filled in by the funeral director.	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	t the time, date	and place, and due to th	e cause(s)
F 8 F 8	Me	29b Signature and title of certifier 29c License number		29d Date signed (Mo.	nth, Day, Year)
	İ	Marinte Me Chill O.C.M.E.		November 7, 200	06
		30. Name and address of person who completed cause of death (Item 23a)			
		Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	21201		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month 12:05 AM 2006 Hrzalia JOV 4a. Facility Name (If not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death AUGSBURG NURSING CENTER BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9-6-1917 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours Min. Months NORTH CAROLINA 1 □ M 2 🖫 F 217-14-9266 89 Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1√1Yes 2 □ No MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5813 GWYNN OAK AVE. 21207 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give △ Year or Dates: 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) HOUSEWIFE DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) HENRY N. LIGHTFOOT HATTIE LILLIAN ELLIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANCINE ASHBY (DAUGHTER) 1410 KING WILLIAM DR. CATONSVILLE, MARYLAND 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation ☐Removal from State \* 4 □ Donation 5 □ Other (Specify) ARBUTUS MEMORIAL PARK 11-10-2006 BALTIMORE, MARYLAND 21. Signature of Funer Service Licens HIBNER Name and Address of Facility REDD FUNERAL SERVICE MOUS D. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or repair failure. List only one cause on each line. Approximate Interval Between Onset and Death Atherosclevet 4 1 ears disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 DUnknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 Tyes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4- Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death

Physician /Medical Examiner

attending physician and for use as the burial-tran

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After this funeral dir

Director:

within 24 hours at To the Funeral D completely filled i

Medical

**Physician** 

/Medical

**Examiner** 

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**Funeral** 

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Midical Examination.

Examiner Physician/Medical δ Completed Be ၉ Certification:

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Sł

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

5 Pending

investigation

6 Could not be determined

29c. License number 737573

Reisterstan

29d. Date signed (Month, Day, Year)

November 6, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Main AD) ZIDEL てて

31. Date filed (Month, Day, Year) State Registra NOV 1 4 2006

1 ANatural

2 Accident

3 Suicide

29a. Certifier

4 - Homicide

32 Registrar's Signature CARRE

DHMH 17 Rev 1/2001

1

Enanvel Melcher 06-08314 UNK UNK

1- For State

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Registrar\_ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day November 2, 2006 1900 hrs E. Melcher 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death

Physician/ Medical Examine	ĺ
Funeral Director	I

permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Baltimore, MD 21215-0036

Physici /Medic xamir

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death

To the Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760,

		1730 West Fayette Street		Baltimore				N/A					
al		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	ay)	If Under 1 Year			Date of Bir	th (MM	(DD/YYYY)	Birthplace (State or Foreign Country)			
or		217-84-1517 1XM 2 F 46	Yrs.	Months Days	Hours	Min.	/VL 3	,19	160	Maryland			
7		Usual Residence of Decedent											
		10a State 10b. County 10c. City. Town or L								10d. Inside City Limits			
once.	ğ		no	re Citi	٧٠					1 X Yes 2 No			
d at	Director	10e. Street and Number		10f. Zip Code			10	-	zen of Wha	•			
iotifi Tipi		1530 W. Fayette Street		212					u.s,	А.			
t pe	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Married Proces?		Decedent of His s, specify Cuban				-	14. Race - White.	American Indian, Black, etc.			
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the		17. Father's Name (First, Middle, Last)			8.Mother's	Name (First			Surname)				
rent,	8	James E. Melcher				ter			112-	A STATE OF THE STA			
atice	٤									, State, Zip Code)			
anu	- 1			ion (Name of cen		. 130				O72]			
her t		Crematory	or other	ar place)									
injury or other traumatic event, the Medical Examiner must be notified at once.	4	4 Donation 5 Other Specify: Wood	La	un Cen	ictery A	NOV IL	2006	B	altin	none (v, M)			
E.		21. Signature of Funeral Service Licensee	22. Na	ame and Address	of Facility	MAYS	on F	un	eral	Service			
	-Î	23a Part I. Enter the disease or complications that caused the death. Do not ex	nter the	8301 C	Mars such as car	mel i	iratory arre	Sal sho	Co n hear	t Approximate Interval			
an al		failure. List only one cause on each line.  Between Onset at											
er		Immediate Cause (Final disease or condition resulting in death)  ALCOROL AIRO NETOIN INITIAL TOTAL AIRO NETOIN INITIAL AIRO NETOIN INITIAL TOTAL AIRO NETOIN INITIAL	LOXI	Callon						Bodin			
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nerai	$\vdash$	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time	e of Inj	ury 28c. Injur	y at Work?	28d. [	Describe h	now inju	Jry occurred	1			
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ın by	<u>;</u> ≌	2 Accident Investigation 3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm,			uilding, etc.	28f. L	ocation (S	Street a	nd Number	or Rural Route Number, City			
filled	등	4 Homicide determined (Specify) found in vaca	ant	rowhouse		Bal	timore	e, M	D/30 W.	. Fayette Street			
completely filled in by the funeral director, page 2 should be	Medical Certification:	29a. Certifier (Check only) Certifying Physician: To the best of my knowledge, death of											
compi	ed j	one) 2 Medical Examiner: On the basis of examination and/or investand manner stated.	stigatio	on, in my opinion,	death occu	urred at the ti	ime, date a	and pla	ice, and due	to the cause(s)			
	Σĺ	29b Signature and title of certifier		29c. License number				29d. Date signed (Month, Day, Year)					
		Josha Leef MIN		O.C.N	1.E.			Nov	ember 3	, 2006			
- 1	- 1	30. Name and address of person who completed cause of death (Item 23a)											

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

ORIGINAL

State

Registrar

Tasha Greenberg MD.

NOV 1

31. Date filed (Month, Day, Year)

			1 = For State Registrar Amend #201	State of Marylar per FH g861	nd / Depart	artment of H	lealth and M Death	lental Hy	giene 006	35967					
H	• Physici	an	1. Decedent's Name (First, Middle, Last)	1ACKIF				2. Date of De Month	Day Year						
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)	ME	4b. City, Town, o	r Location of Death	NOVE	4c. County of De						
	*		5. Social Security Number 6. Sex	LONAL ILE	KE.	MOUN.	T ALR	8. Date of Bir	CARR	Thplace (State or Foreign					
	Funeral Director			.±.7	39 Yrs.	Months Days	Hours Min.	July 2	9,1917 Ne	auntar)					
	and and		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation				10d. Inside City Limits					
	the Marylan 28e-f show	tor	Maryland Carroll		Mount	Airy				1 ☐ Yes 2 💢 No					
	or 28	Funeral Director	10e. Street and Number			10f. Zip Code	74		10g. Citizen of What C	country?					
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36	within 72 hours after death with the Maryland ene. than "natural", or Items 23c or 28e-f show than "natural" or Items 13c or 28e-f show the Modical Ext. all net it ust be notified at	by Fur	1 X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give	- 1	if Yes, specify Cubi 1 ☐ Yes 2 🔀 No	an, Mexican, Puerto Specify:	Rican, etc.)	Black, Wh	<u> </u>					
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Baltimore,	Pages tment of i tant: If it		* 4 □Donation 5 □ Other (Specify)	Met		ematory I			Baltimore						
Bal	permit. Departr Imports any Inji		21. Signature of Funeral Service Liberse Thomas Gregor						land, Inc. ore, Maryl						
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of Vital Records, P	6 50	Completed by P	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did t	obacco use contribute Yes 2 No 3 F	to the cause of death?  Probably 4 Unknown					
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f Vii	Physician: this certificantal director, it	To Be	examiner?	ospital: 1  Inpatient 2	ER/Outpatie	nt 3 DOA Oth	26. Place of Deat ner: 4 Nursing Ho		dence 6 ☐Other (Sp.	ecify)					
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Division	l or Attending after death. Director: After I in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h	ome, farm, st		100 2.0,10	28f. Location (: City or Tox	Street and Number or F	iural Route Number,					
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	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical		sician: To the best of my kno ner: On the basis of examina and manner stated.											
)	To the within To the comp	M	29b. Signature and title of certifier  N B · (Col.)	De fi		29c. Licens	se number 3 c 4 6 9		29d. Date signed (Mor No Veelsey	th, Day, Year)					
	2		30, Name and address of person who co	350, Colum	BIA.	100 Sant	way, (	Co (um	big. Mo	21045					
	Sta Registr		31. Date filed (Month, Day, Year)  NOV 1 4 20	32. Riggistrar's Signa	ature	perto									

			For State	State of Ma	ryland / [	Departm		lealth and I	Mental Hy	giene	n 6	35068
			Registrar  1. Decedent's Name (First, Middle, Last)			Certino	ale or i	Jeani	2. Date of De	Reg. No U	00	3. Time of Death
	Physicia	an							Month	Day	Year	
	/Medic		Frederick Lee Moy			1 41	0. 7	1		4c. County	06	6:459 M
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			Usual Residence of Decedent						Abrir	1945	rial	yland
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	within 72 hours after death with the Maryland ene. than "natural", or iteme 23s or 28s-f ehow the Medical Examiner must be notified at	Funeral Director		2. Was Decedent E Armed Forces?	ver in U.S.	13. Was D		ispanic Origin? (S n, Mexican, Puert	pecify Yes or No	- 14. Race	e - Americ k, White,	an Indian,
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5%	2 = 0 = 1		Irene Moyer, Wife					delphia	Road Jo	* * * * * * * * * * * * * * * * * * * *		
~ 5 or			20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	moval from State	20b. Place of cemeter					20c. Location -		
ii 🗸	Pa trmen tant: lury		4 □Donation 分□Other (Specify)		Metro				09/06			Maryland
$\mathcal{H}_{\mathcal{O}^{\{}}$ Baltimore	permit. Pages Department of Important: If it eny injury or o		21. Signature of Funeral Service Licenses	-		Crem	e and Addres ation	Society	Of Maryl	and, Inc		1 01000
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			shock, or heart failure. List only one Immediate Cause (Final	cause on each line	e. / ^		,	•	. ,			Interval Between Onset and Death
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/isi	Attence death octor;	flca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ry - At home, la	rm, street, fa	ctory, office	1	281. Location (S	Street and Number	er or Rura	l Route Number,
ρi	el or safter safter of in b	Certification;	4 Homicide	building, etc.	. (Specify)				City or Tox	vn, State)		
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate hes been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burral-transit		29a. Certifier 1X Certifying Physic (Check only 2 Medical Examine	er: On the basis of	examination and							
	To the Hos within 24 h To the Fur completely	Medical	one)	and manner stat	ted.	-	29c. License			29d. Date signed		
	5 vit	_	29b. Signature and title of certifier	1	2		23C. LICENSE	n.101		LJG. Date signed	( (IVIOI III )	Day, rear/
			Nany	11/2			Dd	1401		11-09	-04	0
	3		30. Name and address of person what com	pleted cause of de	ath (Item 23a) (	1		0.	. Na'	R-11:	00000	11/2/199
	_		31. Date filed (Month, Day, Yeàr)	32. Registra	r's Signature	) [(	Y1 [1]	Squar	e DIIVE	Dalti	111016	Mazi
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Michael Morris State of Maryland / Department of Health and Mental Hygiene 35969 1. For State Certificate of Death Registrar . Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day November 8, 2006 Medical Examiner Michael E. Morris 0020 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2247 Sidney Avenue Baltimore 5. Social Security Number 7. Age (In yrs last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Months Davs Hours Director 214-64-5927 1 X M 2 6 2<sup>Country</sup>) MD 44 26 19 Ju1v Usual Residence of Decedent 'n 10c. City, Town or Location 10d. Inside City Limits is marked other than "natural", or items 23a or 28a-f show MD Baltimore City 1X Yes 2 No traumatic event, the Medical Examiner must be notified at once, and 2 should be filed within 72 hours after death with the Maryland Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21223 1258 Glyndon Avenue IISA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes Widowed 4 Divorced If Yes. Give Year 1 Yes 2X No specify: Specify: White þ 15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Window Installation Home Finishing of Health and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sidney Morris Jean Lark 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1258 Glyndon Avenue, Baltimore, MD 21223 Vera Morria - Wife If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Burial 2 X Cremation 3 Removal from State crematory or other place) Bayview Crematory 11-10-06 Baltimore, MD Department mportant: Donation 5 Other Specify. 21. Signature of Funeral Service License 22. Name and Address of Facility Bradley-Ashton Funeral Home PA 2134 Willow Spring Road semplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disease, or Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Exsanguination Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b Splenic laceration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical UNPENDED AMENDED attending physician for use as the burial Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d Date of delivery 23b Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day Year 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed be detail ð 1 Yes 2 ✓ No 3 Probably 4 Unknown Cirrhosis Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No Fo the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other<sub>4</sub> DOA Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 this 1 V Yes 28a. Date of Injury (Month, Day,Year) Nov 7, 2006 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Driver auto fixed object collision Natural 2100 hrs 5 Pending 1 Yes 2 V No hours after death the Fo the Funeral Director: 2 🗸 Accident Investigation filled in by 28e Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined Annapolis Road & Monroe Street, Baltimore , MD (Specify) Local Street Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E November 8, 2006 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature 31 Date filed (Month, Day, Year) State NOV Registrar

Please Type or Print in Black Indelible Ink

06-08483

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Day P 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Arnold Arvi 2006 November /Medical 4a. Facility Name (If not institution, give street and number)

Baltimore VA Medical Center 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore. N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 13, 1922 Birthplace (State or Foreign Country)
 NC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 242-38-5716 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental Hyglene. Importent: if Item 27 is marked other than "natural;, or iteme 23e or 28e-f show amy injury or other treumatic event, if a Madical Examination with the radified at once. 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 X Yes 2 ☐ No Baltimore Funeral Director N/A Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21206 4932 Schaub Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WW 11 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Milam Mary Nichols W. James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4932 Schaub Avenue, Baltimore, MD 21206 Marie C. Milam (wife) 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville VA Cem. 11/15/2006 Crownsville, MD <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Fune al Se vice Licensee 9705 Belair Rd., Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cirrhogig **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Peritonitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transi Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown þ s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? completely filled in by the funeral director, page 2 this certificate 2 No 2 No 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 21 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deatl To the Funerei Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cer P 18600 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Greene 9t, Baltimore MP 2120 Liu, MID 31. Date filed (Month, Day, Year) 32 Registrar's Signature State NOV 1 4 2006 Registrar

06-08521 Edward Myers

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

- awara wyers	1- For State Registrar		or Maryland /	•	ate of De		u Wentan		eg No. 200	6 3597
Physician Medical Examine	,	Name (First, Middle,Last						2. Date of Deal Month November		3. Time of Death 2245 hrs
Medical Examine		ward Euger me (if not institution, give			4b. C	ity, Town, or	Location of Deat		4c. County of Death	
		lopkins Bayview M				altimore				
Funeral Director	5. Social Secu		7. Age	(In yrs. last bir		Under 1 Year onths Days			th(MM/DD/YYYY) 9. Bir 3/1964 Co	thplace (State or in NEW untry)YOYR
	Usual Residen	nce of Decedent								
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th the Maryland 23a or 28a-f show any notified at once,		<sub>d Number</sub> Valnut Lan	e		10f	Zip Code 21 (	001	11	ng. Citizen of What Cour	ntry?
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f shouldury or other traumatic event, the Medical Examiner must be notified at once.	11. Marital Sta	utus Married 2 X Married	12. Was Decedent I Armed Forces? 1 Yes 2	Ever in U.S.			panic Origin? ( S , Mexican, Puerto	pecify Yes or No Rican, etc.)	White, etc.	can Indian, Black,
s after ral", o	> Vidow		If Yes, Give Year or Dates:	C		2X No			1	hite
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121 Id be f Aental marked event,		Elmer Myer 's Name/Relationship (Ty	Les paralists	119	h Mailing Add	ress (Strop		Stock	nausen nber, City or Town, State	7in Code)
MD 21 d 2 should th and Me n 27 is ma	Katr	ny Myers-		III:	219 Wa	lnut	Lane A		n, MD 210	01
Baltimore, MD 21215-0036  bernit. Pages I and 2 should be filed within 7  Department of Health and Mental Hygiene Important: If item 27 is marked other than injury or other traumatic event, the Medica		f Disposition  2 🛣 Cremation 3 [ on 5 Other Specify:	Removal from Sta	Evans	of Disposition tory of Other plants of Belleville	ral	Nov	ember 2006	20c. Location - City or Forest	Town, State Hill, MD
Baltii permit. Departm Importa		of Funeral Service Licens	ML.	10				hapel ervice	3 Newpor s Forest	t Dr.
Physician		ter the disease, or compl st only one cause on ea		he death. Do n						Approximate Interval Between Onset and
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760, icate be a physicial the buria	UNPEN		23c. If yes, outcom	e of pregnancy					23d. Date of delivery	
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Sox death c e atten I for us	past 12 mg	No 9 Unknown	4 Pregnant at t 9 Unknown	ime or death	5 Other (	Specify)			1	1
reds, P.O. Box 68 requires that the death certification is been signed by the attending thould be detached for use as		significant conditions	contributing to death	but not resultin	g in the under	ying cause g	iven in Part I.	23e. Did to	bacco use contribute to	the cause of death?
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Records, The law require: ficate has been significate to the significant of the second			<u>.</u>					24a. Was a autop:	sy prior to c	topsy findings available ompletion of cause of
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ician:	25. Was case examiner?	referred to medical	ospital: 1 🗸 Inpatier	4 2 FB/0	utpatient 3		of Death (Check		Desidence of College	
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ion ceath.	1 Natura 2 ✓ Accide	- Ferfully	Nov 8, 2006	<sup>ar)</sup> 175	1 hrs	1_ Y	res 2 🗸 No	Driver auto a	auto collision	
Division of Vital Records, P.O. Box 68 ital or Attending Physician: The law requires that the death certificate death.  For Division of Vital Records, Property of the attending lied in by the funeral director, page 2 should be detached for use as defined in the funeral director.	3 Suicide	e 6 Could not b	e 28e. Place of Inju			tory, office b	uilding, etc.	or Town, St	treet and Number or Ruitate)	
lospita I hours uneral	29a Certifier		(openy) Ivia		· ·	t the time de	to and place and	<u></u>	pney Road, Aberdeer e(s) and manner as start	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of exterior of the physician and page 1.0 physician and page 1.0 physician page 2.0 physician page 1.0 physician page	(Check only one) 2	Medical Examiner:							and place, and due to the	
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2		address of person who correenberg MD. A	ompleted deuse of de ssistant Medica		111 Pen	n Street,	Baltimore, M	D 21201		
Stat Registra		Month, Day, Year) OV 1 4 2006	32. Registrar	s Signature	care					
			A.							

			1 - For State Registrar	State of Marylan	•	ent of Health and ate of Death	-	giene Reg. No. 2 () (	06 35972
			Decedent's Name (First, Middle, Last)		0.0		2. Date of De		3. Time of Death
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to the	Examin	er	4a. Facility Name (If not institution, give st	reet and number)	4b. Ci	ty, Town, or Location of De	ath	4c. County o	of Death
			5. Social Security Number 6. Sex	7. Age (In yrs.	JODITAL D	der 1 Year   If Under 24 H	s. 8. Date of Bir	N/A	Birthplace (State or Foreign
	Funeral Director		213-73-3277	M 2□F 1	Yrs. Month	s Days Hours Mi		17. Year)	Mary land
	D.		Usual Residence of Decedent	110- 67	y, Town or Location				Land Inside City City
	shov	2	10a. State 10b. County MD N/A		timore				10d. Inside City Limits 1    1    Yes 2   No
	28a-1	Director	10e. Street and Number	Dai		Zip Code		10g. Citizen of W	hat Country?
	3a or	D	4304 Springwood A	venue		206		U.S.A.	
	death	Funerai		2. Was Decedent Ever in U Armed Forces?	.S. 13. Was De	cedent of Hispanic Origin?	Specify Yes or No		- American Indian, , White, etc.
9	or its	/ Fu	1 Never Married 2 Married	1 ☐ Yes 2 ♠No If Yes, Give		2X No Specify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Specify:	
Ö	hours fure!,	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educ	Year or Dates:	16a. Decedent's U	rual Occupation		16b. Kind of Bus	white
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פ	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other then "naturel", or items 23a or 28a-1 ahow atto event. Ite Medical Examinational tempillind at	Bec	17. Father's Name (First, Middle, Last)		·	18. Mother's N	ame (First, Middle	, Maiden Sumame	)
Maryland 21215-0036	should that Ment a marked umatic	2	Kieran McCracken			Tracy B			
Ma	d 2 sh th and 7 is m trsum		19a. Informant's Name/Relationship (Typ		9.32W/91 FB	ess (Street and Number or I		5.500	re-an-me
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Itam 27 is marked other then "nature!, or items 23a or 28a-1 show any njury or other traumatic event. It is Medical Examiner must be notified at another.		Kieran McCracken, 20a. Method of Disposition	20b. P	_ 4304 Spr Place of Disposition (/	Ingwood Aven	Date	more, MD 20c. Location - C	City or Town, State
altimore,	Pages nent of I int: if its iry or o		1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State	emetery, crematory o rkwood Cem	· · ·	17/2006	Baltimor	e, Maryland
a	permit. Departm Importa any nju		21. Signature of Funeral Service Licenses					Ruck, I	
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			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the deat cause on each line.	h. Do not enter the m	ode of dying, such as cardi	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
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	/Medical Examiner		1	Due to (or as a conseq Acvic Lu		Leukemia			7.00000
tig.		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	1	Levice			ldays
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Ö,	exe exe		resulting in death) Last	Due to (or as a conseq	uence of):				
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0	ng Pt fter th nneral		27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe	how injury occurred	d
<u>s</u>	Attending Physician: It death. Sector: After this certifically the funeral director.	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	an Blood Min Ab	M	1 Yes 2 No	29f Location /	Ctront and Number	Cont. Cont. About
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	To the Hospital or Attending Ph within 24 hours after death to the Funaral Director. After th completely filled in by the funeral	edical C	(Check only 2 Medical Examine	cian: To the best of my kno er: On the basis of examina					
	thin 2 the 1 mplet	Med	one) 29b. Signature and title of certifier	and manner stated.		9c. License number		29d. Date signed	(Month, Day, Year)
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ſ	2		30. Name and address of person who con	pleted cause of death (ften	n 23a) (Type, Print)				
	)		Jamie M Schwartz		rth Wolfes	t. Baltimore	MD ZIZ	87	
	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 A 2006	32 degistrar's Signa	ture				

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** NOVEMBER 11, 2006 3:00 A M MISHEYEV MIKHAIL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE 4315 LABYRINTH ROAD #2-C BALTIMORE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 **∑** M 2 □ F 0970171917 AZERBAIJAN 89 Yrs. 218-39-8076 Director Usual Residence of Decedent with the Maryland 10c City Town or Location 10d. Inside City Limits 10a State 10b County rai', or items 23s or 28s-f show Examiner must be notified at 1 ☐ Yes 2 X No BALTIMORE BALTIMORE Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21215 AZERBAIJAN 4315 LABYRINTH ROAD #2-C filed within 72 hours after death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 1 Never Married 2 X Marned 0 WHITE Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education grade completed (Specify only highest Coilege (1-4or 5+) Elementary/Secondary (0-12) **ECONOMIST** SALES 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Menial Hy Important: if Item 27 is marked othe any linjury or other traumatic event, ODES. 17. Father's Name (First, Middle, Last) Be NAFTALIEVA MISHEYEV LIUB0V YAKOV 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BALTIMORE, MD 21215 4315 LABYRINTH ROAD #2-C RIVA MISHEYEV / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) ZION 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State IBERTY PARK OF SHAAREI 11/12/06. RANDALLSTOWN, MD 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Tolac Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final metastatic concer unlinum months Probabo **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed ettending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) signed by the e detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ OPD 1 Yes 2 No 3 Probably 4 Unknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performedi/ 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 20 No 1 Inpatient 5 Residence 6 □Other (Specify) ို 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA After this 28c. Injury at Work? 28a. Oate of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the f Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide within 24 hours a
To the Funerei t
completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the dause(s) and mainten as series.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certi-00057926 2006 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) harles of Balkmore awdan N. M. 6565 31. Date filed (Month, Day, Year) 32. Registrar's Signature State COLLEGE. 2006 Registrar 4

			for State Registrar	State of Maryland		artment <i>tificate</i>			and M		ene g. N& 0	06	35974
	Dharaisi		1. Decedent's Name (First, Middle, Last)			-				2. Date of Death Month	Day	Year	3. Time of Death
	Physici /Medic	-	Dorothy Fleagle No	orton						NOVEM	BER 7	. 2004	8:12FM
	Examin	er	4a. Facility Name (If not institution, give s Saint Joseph						Tows		4c. County	Balt	imore
1	Funeral		5. Social Security Number 6. Sex	M 2DE	st birthday) Yrs.	If Under Months	1 Year Days	Hours 1		8. Date of Birth (Month, Day, June 30	Year) 1016	9. Birthpla Count	ace (State or Foreign hy) MD
	Director	}	263-01-8509 Usual Residence of Decedent	<u>X</u> 90						June 30	1910		1.117
	yland yland		10a. State 10b. County	10c. City,	Town or Lo	cation						10	d. Inside City Limits
	Mar.	ţŏ	MD Baltimore	e : Co	ckeys	ville							1 □ Yes 2√∑ No
	or 28	lre	10e. Street and Number			10f. Zip				10	g. Citizen of		try?
	ath w	ia	10535 York Rd. Apt.				210				USA		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene.  Depertment of Health and Mental Hygiene.  Important: If Item 27 is marked other then "patural", or Items 23a or 28a-f show eny Injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	<ul> <li>12. Was Decedent Ever in U.S. Armed Forces?</li> <li>1 ☐ Yes 2 No If Yes, Give Year or Dates:</li> </ul>		Was Deced f Yes, spec 1 ☐ Yes	ify Cuba	spanic Orig n, Mexican Specify:	, Puerto F	cify Yes or No- Rican, etc.)	Bla	ce - America ck, White, e y: <b>whit</b>	etc.
Ŏ	72 ho	ted	15. Oecedent's Educ (Specify only highest grade		16a. Deced	dent's Usua	l Occupa	ation during most	t of workin	100	6b. Kind of B	usiness/Ind	ustry
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ž	should ind Men marke umatic	L O	Arthur Noah Fleagle  19a. Informant's Name/Relationship (Type		10h Mailir	ng Address	(Street :			Route Number,		State 7in	Code)
Ma	th an		John S. Norton/son			-				rederic	-		
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ä	Page 4		Bryan W. Clary	My	1.0	emmon W. P	. Fun adon	eral ia Rd	Home	of Dula	aney va . MD 2	alley, 1093	, inc.
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	Sta Regista		31. Date filed (Month, Day, Year) NOV 1 4 200	32 Registrar's Signatu		and it							

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Ţ.	/Medic Examin		4a. Facility Name (If not institution, ga		-)		4b. City, Town, or	Location of			c. County of Deat	
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	ms 2	Funeral	11. Maritaf Status	12. Was Deceden Armed Forces	t Ever in U.S	S. 13. \	Was Decedent of H	ispanic Origin	in? (Specify	Yes or No-	14. Race - Ame	
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5	be filed within 72 hours after death with the Maryland de Hygiene. 4 Hygiene de Other than "netural", or Items 23s or 28s-f show dother than "netural", or Items 23s or 28s-f show event, The Medical Examiner must be notilised at	Completed	15. Decedent's l (Specify only highest g			(Give	lent's Usual Occup kind of work done o DO NOT use retired	during most o	of working	16b.	Kind of Business/	Industry
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ary	should be man		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street	and Number	or Rural Ro	ute Number, City	or Town, State, Z	(ip Code)
Σ	and 2 saith a n 27 i sr tre		Joseph J. O'Conr	nor		5005	Wethered	lsville				
ore	of He		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3	□Removal from State	1 6	ace of Dispo metery, cren	sition (Name of natory or other plac	e)	Date	20c.	Location - City or	Town, State
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiens. I important: If tem 27 is marked other than "natural; or items 23a or 28a-1 ehow eny injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice K1M MaC	Leod 100	/	22	Name and Address Layton Fu 102 South	ss of Facility Ineral 1 Main	Home St. W	oodstow	n. NJ 080	)98
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Вох	death certifica ettending pl	M/NE	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom 1 ☐ Live birth			Ectopic pregnancy				23d. Date of deli	•
о Ш	The law requires that the death certific sie has been signed by the ettending p bage 2 should be detached for use as	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant a 9□ Unknown	at time of de		Other (specify)			_	Month	Day Year
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0	ng Pt fter th		27. Manner of Death  1 Natural 5 Pending	28a. Date of Inj (Month, D	iury ay Year)	28b. Time of Injury	Worl	k?		Describe how in	ury occurred	
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Division of Vital Records, P.O.	af or At after of Direct d in by	Certification:	4 Homicide determine	d 286. Place of it	njury - At hor etc. <i>(Specify,</i>	me, farm, str	eet, factory, office			ocation (Street a City or Town, Sta		ral Route Number,
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	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manners	,		29c. Licens	e number		29d. D	ate signed (Monti	n, Day, Year)
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	10		30. Name and addre s of cerson wh	~ ·	death (Item	23a) (Type,	Print) (hojo	Ign	<i>y</i> /	a tonsu:	vember 7 16 Ma	5/10
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend item#9, perFH, G861, 11/14/06 TICertificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Gwendolyn Odoms 3:04 AM NOV. 2006 /Medical 10 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner University Maruland Medical Center Baltimore 0 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2**X** F 39 Director 216-06-4947 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits MD NA Baltimore Director 1 XYes 2 No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 3605 Bowers Ave Apt B 21207 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes X☐ No If Yes, Give Year or Dates: Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Be Completed by Specify: Black 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry if Health and Mental Hygiene. Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12th grade <u>Housekeeping</u> Hospital other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Odoms Corinda Williams 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21223 19a. Informant's Name/Relationship (Type. Print) 1900 West Baltimore Street Apt A, Balto, Chenee Odoms-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of IImportant: If ite
any injury or ot
once. N Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 11/16/06 Randallstown, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore and. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Ip mediate Cause (Final isease or condition resulting in death) **Physician** Electrical Pulsdess Activity /Medical Due to (or as a consequence of): Examiner Thrombotic thrombocy topenic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. the attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an was a autopsy performed?
Yes 2 \sum No has Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: P 1 3mpatient 2 ER/Outpatient 3 DOA this in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Nov. 10 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baitimore W Greene 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Director

Funeral

Completed by

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Please	e Type or Prin					-	
For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of H <i>rtificate of</i>			ene g. No. 2 () () (	5 35977
Decedent's Name (First, Middle, L.)	.ast)				2. Date of Death		3. Time of Death
Catherine Pa	v1ov				Novembe	Day Year er 2. 20	006 9:05 ₽ <sup>M</sup>
4a. Facility Name (If not institution, g			4b. City, Town, o	r Location of Death		4c. County of De	
Gilchrist Ho	spice		Tows	on		Baltin	nore
	Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day,	9 B	irthplace (State or Foreign Country)
224-56-7633	1□M 2\XF 6	4 Yrs.	Months Days	Hours Will.	3-24-1		VA
Usual Residence of Decedent							
10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
MD Balt	imore	Dundal	k				1 □Yes 2 X No
10e. Street and Number 6909 Dunmanwa	y, Apt. D	<b>-</b> 5	10f. Zip Code 2 1 2 2 2		10	g. Citizen of What 0	Country?
11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of H If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2 ☐X\ If Yes, Give Year or Dates:	lo	1 ☐ Yes 2 ☐ No	Specify:		Specify: Wh	ite
15. Decedent's (Specify only highest of	Education		dent's Usual Occup	oation during most of work		6b. Kind of Busines	s/Industry
Elementary/Secondary (0-12)	College (1-4or 5	+) life.	Estheti	d) _	King	Skin_C	
17. Father's Name (First, Middle, La	st)		ESTHELL		ne (First, Middle, M		ale
John Aberneth				Cathe	rine Poa	at	
19a. Informant's Name/Relationship	(Type. Print)	19b. Maili	ng Address (Street	and Number or Ru	ıral Route Number,	City or Town, State	, Zip Code)
Ana Soulios -	Daughter	2091	Harbor	Way, Ma	artinsv	ille, NJ	08836
20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Specar)  21. Signature of Eugeral Service Lice	cify)	Bayview	matorý or other pla Cremat	ory 11.	-4-06		orTown, State ore, MD neral Home,
1 9 1/1 h						Road, 2	
23a. Part1. Enter the disease, or co shock, or heart failure. List on	emplications that caused by one cause on each lin	the death. Do not en	-3		or respiratory arre	st,	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	a consequence of)	CAM	cer			month
	200 10 (0) 100						
Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):					
Cause (Disease or injury that initiated events resulting in death) Last	c						
resulting in death) East	Due to (or as a	a consequence of);					
IF FEMALE:	23c. If yes, outcome	nf prognanov					
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 ☐ Fetal death 3 [	□Ectopic pregnand □ Other (specify) _	у		23d. Date of d Month	elivery Day Year
Part II. Other significant conditions	s contributing to death bu	ut not resulting in the u	inderlying cause gi	ven in Part I.	23e. Did tob		to the cause of death?  Probably 4 □Unknown
					24a. Was an autopsy perform	/ prior t	autopsy findings available o completion of cause of
					1□ Yes 2	□No 1□Y	
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie	nt 2 ☐ ER/Outpatie	nt 3□ DOA Ott		ath <i>(Check only one</i> Iome 5 ☐ Beside	nce 6 Other (S)	necify) Horse 127-
27. Manner of Death	28a. Date of Injur		of 28c. Inju		28d. Describe hor		1102/100

Examiner Physician/Medical Completed by Be Certification: To Medical

Part II. Other si 25. Was case re examiner? 1 ☐ Yes 2 1 Natural (Month, Day Year) Injury Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide

27. Manner of D 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a.	Certifier
	(Check only
	one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 25205

30. Name and address of person who completed cause of peats (Item 23a) (Type, Print)

32. Fegistrar's Signature

State Registrar

within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 ?

		St State-Amend item#20b, perF Registrar  1. Decedent's Name (First, Middle, Last)			noate of I		. Date of Death		3. Time of Death
Physician /Medical	1	JOHN	W. PROCTO				OCTOBER	<sup>D</sup> 27 2006	2:52 Рм
Examiner	r	4a. Facility Name (If not institution, give street SOUTHERN MARYLAND Ho		-	4b. City, Town, or CLINTO	Location of Death		4c. County of Death PRINCE GI	
uneral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia		If Under 1 Year Months Days		Date of Birth (Month, Day, Ye		place (State or Foreign
irector		577-26-3856	<sup>2   F</sup>   82	Yrs.	VIOLITIS Days		AUG. 10	1924 MAR	YLAND
* =	+	Usuel Residence of Decedent  10a. State 10b. County	10c. City	, Town or Loca	tion		<u> </u>		10d. Inside City Limits
item 27 ie marked other than "natural", or items 23e or 28s-f show other traumatic event, the Medical Exantical trust be notified at To Ge Completed by Funeral Director	يَوْ	MD PRINCE GEO	ORGE'S	HYATTS	/ILLE				1 Yes 2 □ No
be counted	S E	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cou	untry?
rivat	Lai	6427 24th PLACE	Was Decedent Ever in U.S	S 13 W	20782	enanic Origin? (Speci	fy Vas or No-	U.S.A.	ican Indian
irer must	E I	1 Never Married 2 Married 1	Armed Forces? 1.Γ25Ves 2.Γ.No.A.rm	V		spanic Origin? (Speci n, Mexican, Puerto Ri	can, etc.)	Black, White	, etc.
À	200	3 ∰Widowed 4 □ Divorced	If Yes, Give Year or Dates: 4/49-		Yes 2 XNo	Specify:		Specify:	BLACK
jete	ete	15. Decedent's Education (Specify only highest grade con	n mpleted)	16a. Deceder (Give ki	nt's Usual Occupa nd of work done of NOT use retired	ation furing most of working }	161	b. Kind of Business/I	ndustry
Completed	티	Elementary/Secondary (0-12) C	College (1-4or 5+)		DRIVER	<b>,</b>		GOVERNMEN	Т
Be		17. Father's Name (First, Middle, Last)				18. Mother's Name (	First, Middle, Mai	den Sumame)	
Ţ	0	CLINTON PROCTOR				MARGARET			
		19a. Informant's Name/Relationship (Type, F				G AVENUE		•	20746
other	ł	20a. Method of Disposition	20b. PI	lace of Disposit		las de Da	e 20c	c. Location - City or 1	own, State
	1	1 ဩBurial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	oval from State		ION CEMI			LINTON, MA	RYLAND
any njury or o		21. Signature of Funeral Service Licensee	1/		Name and Addres	os of Facility J.  DOVER ROAD		NS FUNERAL ER, MARYLAN	
	1	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one ca	ons that ceused the death	n. Do not enter	the mode of dyin	g, such as cardiac or	respiratory arrest	,	Approximate Interval Between
ian		Immediate Cause (Final disease or condition	Alshe	mh	[ Deve	re) de	urent	u	D and Death
cal ner		resulting in death)	Due to (or as a consequ	uence of):	4.1.	Lui 7			Im
وَ ا	Je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	ence of):	Drug-				W W WES
Fxaminer	E a	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	147	ner	my	_			14
		Tosuling in deality saut	Due to (or as a confeed)	dence of):					
	edic	d							
cian/Me	Physician/Me	23b. was decedent pregnant	If yes, outcome of pregnar		ctopic pregnancy			23d. Date of deli	very Day Year
hvaici	SICE		4☐Pregnant at time of de 9☐ Unknown		Other (specify)			Month	Day Fear
4		Part II. Other significant conditions contribu	uting to death but not rest	ulting in the und	erlying cause give	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
	D D		-				1 ☐ Yes	2 ⊠ No 3 □ Pro	obably 4 Unknown
noiete	Completed						24a. Was an autopsy	24b. Were au	opsy findings available ompletion of cause of
orector, page.	E						performed	d? death?	2⊠ No
8	Be	25. Was case referred to medical examiner?	and the second			26. Place of Death	Check only one		
a (	0	1 ☐ Yes 2 ☑ No Hospi 27. Manner of Death 28	1   Inpatient 2	ER/Outpatient 28b. Time of	35 DOA Oth	4   Norsing Floring	5 Residence	e 6 Other (Specinium occurred	ify)
tion.	HOLE	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Injun Worl	<br Yes 2 □No			
	tifica	action in a second and ha	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stree	t, factory, office	28	f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
y   1									
iled in by the tuneral			an: To the best of my know On the basis of examinat						
erery mired in by the		(Check only 2 Medical Examiner: one)	and manner stated.						
Madical Certifica	Medicai Ceri	(Check only 2 Medical Examiner: one)  29b. Signafure and tylle of certifier	and manner stated.	1	29c. Licenso	number	29d.	Date signed (Month	, Day, Year)
completely filled in by the		one)	and manner stated.	>	29c. License	24535	29d.	Date signed (Month	1
completely filled in by the I		one)	Meted cause of death (Item		D-	24535		10,28,0	1

		4	For State Registrar	State of Maryla		partment of Fertificate of			iene	06 35979
			Decedent's Name (First, Middle, Last	st)				2. Date of Death Mgnth		3. Time of Death
	Physicia /Medic		Theda A.	Pittinger				Nov.	12	06 1100 am
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	Location of De		4c. County	of Death
				es Hospy	tal	v) If Under 1 Year	If Under 24 H	2		9. Birthplace (State or Foreign
	Funeral		5. Social Security Number ()6. S	ex 7. Ager(in y	rs. last birthda Yrs.	Months Days		April 24,	<sup>Y</sup> 1918	Country) Maryland
	Director	-	214-01-1335 Usual Residence of Decedent	0	2			<u>†</u>		
	yland how		10a. State 10b. County	10c.	City, Town or	Location				10d. Inside City Limits
	Ba-fe	cto	Maryland Baltin	ore	Caton	sville				1 □ Yes 2 X No
	or 28	Directo	10e. Street and Number			10f. Zip Code		10	Og. Citizen of	What Country?
-	ath w	ra	719 Maiden Choic		- 110	212				ates of America
	item de	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces?	10.5.	<ol> <li>Was Decedent of F If Yes, specify Cub</li> </ol>	an, Mexican, Pu	erto Rican, etc.)		ck, White, etc.
<u>ي</u>	irs all	by F	3 ₩idowed 4 Divorced	1 ☐ Yes 2 😿 No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specity:		Specif	y: White
21215-0036	be illed within 72 hours after death with the Maryland Hydjone. At Hydjone. At Hydjone. At Other then "naturel", or items 23s or 28s-f show event, it a Medical Examinar must be notified at	Completed by Funeral	15. Decedent's Ed		16a. Dec	cedent's Usual Occup ve kind of work done	pation	vodena	16b. Kind of B	usiness/Industry
7	en "r	nple	(Specify only highest gra	College (1-4or 5+)	life	. DO NOT use retire	d)		O II	
SA .	Hygien Hygien other th	S	12	0		lome Maker		lama (Sint Middle A	Own H	
_	tal H	Be	17. Father's Name (First, Middle, Last,	)				ame (First, Middle, A	_	ne)
Maryland	should be and Mental is marked o	၉	Ralph Price  19a. Informant's Name/Relationship (	Tuna Print)	19h Ma	iling Address (Street	Mary	L. Hanke Rural Route Number,		State, Zip Code)
<u>a</u>	d 2 sl th an th an treur					•		_	-	sburg, FL 33715
ຍົ	Heal Heal tem 2		20a. Method of Disposition		b. Place of Dis	position (Name of				- City or Town, State 21207
ᅙ	ages ant of st: If i		1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specif			rematory or other plant Cemetery	11,	/14/06	Woodla	wn, Maryland
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked eny injury or other treumatic evonce.		21. Signature of Funeral Service Licer		. ,					eral Directors,
	40 ± 4 4		23a, Part1. Enter the disease, or com	polications that caused the	leath Do not e					Maryland 21133 Approximate
F	hysician		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.  a. Acute			ilure			Interval Between Onset and Death
	/Medical Examiner		<b>f</b>	Due to (or as a con	sequence of):					
		-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a con	sequence of):					
	icate be executed physicien and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
o	be executed icien and burial-transit	Exa	resulting in death) Last	Due to (or as a con	sequence of):					
8760,	ite be iysicie ne bui	Cal	•	d.						
89	ntifica ng ph	P	IF FEMALE:							
Вох	death certificate e attending phys id for use as the	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of ore 1 Live birth 2 F	etal death	3 □Ectopic pregnanc	;y			ate of delivery onth Day Year
<u>.</u>	at the dea by the a tached fo	/slc	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time 9☐ Unknown	of death :	5 Other (specify)				
О. О.	hat the		Part II. Other significant conditions	contributing to death but not	resulting in the	underlying cause gr	ven in Part I.	23e. Did tob	acco use con	tribute to the cause of death?
ds,	uires that signed t d be det	d by	A .	male				1 🗆 Ye	s 2 No	3 Probably 4 □Unknown
Records,	The law requires that the ste hes been signed by th page 2 should be detache	Completed	Severe Obs	Luchup CI	2000	Vano.		24a. Was a	n 24b.	Were autopsy findings available
e E	The lay ate hes page 2	Ę	severe Ons	Truesto C DE	ap c	()140		autops perform	ned2	prior to completion of cause of death?
			25. Was case referred to medical				26 Place of F	1 ☐ Yes 2 Death (Check only on		1 Yes 2 No
Vita	9 0 7	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: Inpatient	2 ER/Outpat	tient 3 DOA Ot	han	Home 5 ☐ Reside		her (Specify)
			27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Time			28d. Describe ho		
<u>o</u>	Attending r death.	atlo	1-☑Natural 5 ☐ Pending 2 ☐ Accident investigation	on	.,,		]Yes 2□No			
	or Attency after death Director:	Certification:	3 Suicide 6 Could not to determined			street, factory, office		28f. Location (St City or Town	reet and Num n, State)	ber or Rural Route Number,
٥	oital or urs afte rei Dir lied in			1						
	To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by the	edical	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hysician: To the best of my miner: On the basis of exar and manner stated.	knowledge, de nination and/or	eath occurred at the t investigation, in my	ime, date and pla opinion, death or	ace, and due to the ca ccurred at the time, da	ause(s) and mate and place	anner as stated. , and due to the cause(s)
	ithin 2 of the	Mec	29b. Signature and title of certifier	and marrier stated.		29c. Licen	se number	2	9d. Date signi	ed (Month, Day, Year)
)	S T S T S			. 0		n	44372	A.	combo	11 2 6
1	7		30. Name and address of person who	completed cause of death	(Item 23a) (Tvo	De, Print) Den ee	n Bowl	in, wb	CINDE	10/ 2000
	0		Saint agnes Hosi							
	St	ate	31 Date filed (Month, Day, Year)	32. Registrar's S	ignature	Sparte				
施	Regist	rar	NOV 14	2006	1					

Thedo Pittinger

			1 - For Amend item#23a-l	State of Marylar permo, Sol, II	)d.//Depa /14/06 11 <i>Cer</i>	ertment of tificate of	Health and Death	Mental Hygi	ene 006	35980
	Physici	an	1. Decedent's Name (First, Middle, Las	A		0-6		2. Date of Death Month	Day Year	3. Time of Death
	/Medi	cal	42 Facility Name (If not idetitution give	Anthor	Y	Ab City Town	or Location of Dea	OCTOB	4c. County of De	
1	Examir	ner	4a. Facility Name (If not idstitution, give		nter		Tov	vson	Ba	ltimore
	Funeral Director		5. Social Security Number 6. Social Security Number 6. Social Security Number 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs.	Ast birthday)	If Under 1 Yea Months Days			Year) 23 N	inthplace (State or Foreign Pountry)
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 ie marked other then "naturel", or iteme 23e or 28e-f ehow other treumatic event, the Medical Examinational be rigilised at	tor	10a. State 10b. County	more 10c. Ci	ar V	ille				10d. Inside City Limits
	3a or 28	Funeral Director	10e. Street and Number	1 Ct Apt	)	10f. Zip Code	1234	10	g. Citizen of What C	Country?
"	fter death	Funer	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 ☑ Yes 2 ☐ No		Yes, specify Cu	ban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Wh	ite, etc.
-0036	hours a	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates: WW	44	ent's Usual Occi		1	Specify: (c)	
21215-0036	within 72 ene. then "ne	Completed	(Specify only highest gra	College (1-4or 5+)	(Give I		during most of we	prking /	netropo	litan
	ould be filed within Mental Hygiene. Merked other then satic event, the Matic event, the Metric event,	Be	17. Father's Name (First, Middle, Last)	Para	79		18. Mother's Na	me (First, Middle, M		nsurance
Maryland	2 should and Men ie marke reumatic	7	19a. Informant's N me/Relationship	ype, Print)	19b. Mailin	g Address (Stree	at and Number or F	Jury / Route Number,	City or Town, State,	Zip Code)
	0 0		20a. Method of Disposition  1 Burial 2 Cremation 3		Place of Dispos cemetery, crem	sition (Name of patory or other pl	(ace) 10-	Date 2	Oc. Location - City o	r Town, State
Baltimore	permit. Pages Department of important: If it eny injury or o		4 □Donation 5 □Other (Specify  21. Signature Funeral 3 in 15 Cen	1	rkw	OD Cem	etry "	habel an	d Crema	no services
8	83558	1 (2	MAD TOR		Pa	nwik.	8800 Ha	rford rd f	arkville,	mD 21231-/ Approximate
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	V		LOCKS	ure	c or respiratory arre	st,	Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consection MULTI-SY)		IRGAN F	AILURE			-6 HOURS
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	quence of):					
8760,	cate be executed physicien and the burial-transit	dical Exa	resulting in death) Last	Due to (or as a consec	quence of):					
9	certifical Iding phy Ise as th	/Medi	IF FEMALE:	23c. If yes, outcome of pregn	ancy				23d. Date of de	alivery
P.O. Box	that the death certific ed by the attending p detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	al death 3 🗌	Ectopic pregnand Other (specify)			Month	Day Year
	8 5 e		Part II. Other significant conditions co	ontributing to death but not res	sulting in the un	derlying cause g	ven in Part I.	23e. Did toba	1	to the cause of death?
Division of Vital Records,	has been sige 2 should	Completed by						24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
tal	ysician: The lis certificate hadirector, page	a)	25. Was case referred to medical				26. Place of De	1 ☐ Yes 2 ath (Check only one	XNo 1 ☐ Ye	s 2 No
Ţ	Physici this cer al direct	To B	evaminar?	Hospital: 1 Vinpatient 2□	ER/Outpatient	3□ DOA O	her	Home 5 Residen		ecify)
o uoi	Attending Physician: It death. Cotor: After this certification by the funeral director.		27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Pate of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju We M 1 [	ıryat ork? ]Yes 2 ☐ No	28d. Describe how	r injury occurred	
Divis	al or Atte s after des i Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, stre	et, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	lural Route Number,
	To the Hospital or Attending Physical Within 24 hours alter death. To the Funerel Director: Afler this completely filled in by the funeral directors.	Medical C	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	ysician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the testigation, in my	ime, date and plac opinion, death occ	e, and due to the cau urred at the time, dat	use(s) and manner a e and place, and du	s stated. e to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certified			29c. Licer	se number	290	d. Date signed (Mon	th, Day, Year)
) j	Ott		) Ho	7/1		DØ	257593		10/2	6/06
B	, 1		30. Name and address of person who of SANG NA. M. D.			·	CON MAD	VI ONITS OF	C10 4	
	Sta	te	SANG NA, M. D.  31. Date filed (Month, Day, Year)	32. Registrar's Signa	R DRIV	Sell 1	POIA* WHK	YLAND 21	<u> </u>	
	Registr	ar	NOV 1 4 2	JUb BRAGE.	San San San San San San San San San San	Charles of the control of the contro				

DIVISION OF VITAL RECORDS, P.O. Box 68/60, A Baltimore, Maryland 21.	
ne hospitat or Attending Priysicient: The law requires that the death certificate be executed X X X X X X X X X X X X X X X X X X X	Department of Health and Mental Hygiene Important: If Item 27 is marked other the

Phillips, charlene

			For State Registrar	State of Ma	ryland / Dep. <i>Ce</i>	artment of H <i>rtificate of L</i>			giene 2	006	35981
			Decedent's Name (First, Middle, La	st)				2. Date of Dea	ıth		3. Time of Death
Н	Physici /Medio		CHARLENE PHILLI	PS				Nov	i O	2006	19:06 PM
12	Examir		4a. Facility Name (If not institution, giv			4b. City, Town, or			4c. Cou	inty of Death	
			ST AGNES	ItOSPIT.		BALTI If Under 1 Year	MORE,			N/A	
	Funeral Director		220 30 0001	M 2√F 7. Age	(In yrs. last birthday) 66 Yrs.	Months Days	Hours Min.	8. Date of Birth Month Day 3-23-1	946	MARY	place (State or Foreign LAND
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				1	10d. Inside City Limits
	Maryll	ļo	MD. N/A		BALTIM	IORE					1 XYes 2 No
	r 28a	rec	10e. Street and Number			10f. Zip Code		1	10g. Citizen	of What Cour	ntry?
	th with	a D	3403 ELGIN AVE.			21216			US	A	
21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene." marked other then "natural", or items 23a or 28a-f ehow imatic event, Ita Medical Examinar must be notitled at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Z Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☐ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		Race - Americ Black, White, cify: BLA	etc.
Ģ	72 ho	ted	15. Decedent's E. (Specify only highest gra		16a. Dece	dent's Usual Occupa	tion	ing	16b. Kind of	f Business/In-	dustry
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ດ :	filed w Hygien other th	S		-1-	ELEC	IKICAL IE	18. Mother's Nam	o /First Middle		INGHOU	SE ————————————————————————————————————
	buld be fi Mental H erked otl atic ever	Be	17. Father's Name (First, Middle, Last,	,						name)	
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	and 2 sealth and 2 sealth and 27 is		MARIO PHILLIPS (			O ELKTON				1/1	
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	/Medical Examiner		Todaling in doubly		consequence of):	' 0 : = Of '	6"				NATURE OF THE PARTY OF THE PART
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39	ing ph e as t	<b>6</b> 3 T	IF FEMALE:		and the second						
P.O. Box	law requires that the death certifines be been signed by the ettending to 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at t 9□Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			1	Date of delive Month	ery Day Year
. i	s that ned b	by Pi	Part II. Other significant conditions of	ontributing to death but	t not resulting in the u	nderlying cause give	n in Part I.	23e. Did to	bacco use co	ontribute to th	ne cause of death?
Division of Vital Records,	w require been sig should b	ed b	End	stage or	enal o	lisease		1 □ Ye	s 2 No	3 ☐ Prob	pably 4 □Unknown
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ř	The steh	ĕ	itype	Trensie	n			perform	med?	death?	
ıta	ysicien: The law his certificate hes t director, page 2 s	Be	25. Was case referred to medical examiner?				26. Place of Deat	Check only on	18)		
5	Attending Physicien: r death. sctor: After this certifice by the funeral director,	၉	1 ☐ Yes 2 ☑ No	Hospital:			4 LINUISING HO	me 5 Reside			v)
ב	After After funera	on	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Yeer) 28b. Time of Injury	Work	at ? es 2 □ No	28d. Describe ho	ow infury occ	curred	
Si	death death stor: / the	Cat	2 Accident investigation 3 Suicide 6 Could not b		y - At home, farm, str			28f. Location (St	reet and Nu	mher or Rura	I Route Number
2 }	를 를 를 들	Certification;	4 ☐ Homicide determined	building, etc.	(Specify)	oot, lactory, omoo		City or Town	n, State)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	Hospita 4 hours Funere ely fille	Medical C	29a. Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of niner: On the basis of and manner state	examination and/or in	h occurred at the time vestigation, in my op	e, date and place, inion, death occurr	and due to the ca ed at the time, d	ause(s) and ate and plac	manner as st	ated. the cause(s)
	within 2 To the complet	Me	29b. Signature and title of certifier			29c. License		.2	9d. Date sig	ned (Month, I	Dey, Year)
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			NEERA		ODDU /	51 MUI	100	IUSTII	1) [		
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			For State Registrar	Ī	State of I	Marylan		artmen <i>tificate</i>		ealth and N Death		giene (	006	35982
	Physicia /Medic	_	Decedent's Name (First,  J	Middle, Last) OSEPH			PL	ATTMA	N		NOVEMBI		2006	3. Time of Death 9:20 A M
	Examin		4a. Facility Name (If not inst		VILLA			4b. City,	Town, or	PARKVILL	.E		BALT	IMORE
£	Funeral Director		5. Social Security Number 164-16-6740		M 2□F 7.	Age (In yrs. I	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 11/25/	1908	9. Birthp Cour	place (State or Foreign htry) KY
	Maryland f ehow	ō	Usual Residence of Deceder 10a. State 10b. Communication 10b. Communic		RE.	10c. City	, Town or Lo	cation					1	0d. Inside City Limits 1 ☐ Yes 2 💢 No
	deeth with the Maryland me 23a or 28a-f ehow r must be nutilised at	1 Director	10e. Street and Number 8834 WALTHE					10f. Zip	Code	21234		10g. Citizen d	of What Cour	usa
036	urs after deeth	by Funeral	11. Marital Status  1 Never Married 2 3 Widowed 4 Div	Married 12	2. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	ss? <b>X</b> No		Was Deced f Yes, spec	-	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. R B	ace - Americ lack, White, city:	
Maryland 21215-0036	d within 72 hours after piene. r than "natural", or ite the Madical Exemina	Completed	15. De (Specify only Elementary/Secondary (C	edent's Educa highest grade	ation completed) College (1-4	or 5+)	16a. Deced (Give life. DRIV	kind of wor DO NOT us	il Occupa rk done d se retired	ation during most of won ()	king	16b. Kind of TRUCK		dustry
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ી ટેં તે ભેખ Baltimore, Ma			19a. Informant's Name/Rel DOROTHY CHAR  20a. Method of Disposition 1 Burial 2 Crem. 4 Donation 5 Ott  21. Signature	EN PLA	TTMAN /	ate C	8834 lace of Dispo emetery, crei SHARO	WALTH Institute of o ON CEN 2. Name an	HER I	RY 11/1	D - PARK Date 13/2006 DL LEVIN	VILLE, 20c. Locatio SPRIN SON &	MD 21 n - City or To GFIELE BROS.	.234 own, State
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of Vital Records.	The law requate hes been pege 2 should	Completed										an 24 lsy rmed? 2 No	b. Were auto prior to co death? 1 🗆 Yes	opsy findings available impletion of cause of
F) H	To the Hospital or Attending Physicien: The within 24 hours etter death. To the Funaral Director: After this certificate he completely filled in by the funeral director, page	Certification; To Be	2 Accident 3 Suicide 6	_	28a. Date of (Month,	Day Year) I Injury - At ho	28b. Time of Injury	f a	8c. Injur Wor 1 □	er: 4 Nursing H	ath (Check only of lome 5 Residence 128d. Describe has 28f. Location (5	dence 6 00	curred	fy)  al Route Number,
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		•	for State Registrar				rtificate				_	Reg. No.2	006	35983
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	Physicia /Medic		DOROTHY	RAK						. D	NOVEM		8 200	615:35 PM
	Examin	er	4a. Facility Name (If not institution, give HARBOR HO	SPITAL			4b. City, To		ocation of MOR			4c. Cou	inty of Death N/A	
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	and w	}	Usual Residence of Decedent  10a. State 10b. County		10c. City	r, Town or Lo	cation							10d. Inside City Limits
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	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or itema 23a or 28a-f ahow event, the Modical Examinar must be notified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Armed Forces: 1 [Yes 2]	?					Puerto	ecify Yes or No- Rican, etc.)		Black, White	, etc.
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ylar	should by	To E	Joe J	ones							Smith			
Maryland	and and		19a. Informant's Name/Relationship (7				ng Address (S st Tal				al Route Numbe + 1 - 1			1and 21225
	1 and 2 Health Iem 27 other tr		James Rarick / H	usbanu	20b. Pl		sition (Name natory or other			7.45	Da.I. (		on - City or T	
٥			1 🖾 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify				ll Ceme			1/13	/2006	Baltin	nore,	Maryland
Baltimore,	permit. Pages 1 al Department of Hea Important: If Item any Injury or othe Once.		21. Signature Funeral Service Licen	200 W 200 W	da	22		Address	of Facility	Go	nce Fun	eral S imore,	Servic Mary	e, P.A. land 21225
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	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical (		ysician: To the best liner: On the basis of and manner s	of examinat									
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No-2. Date of Death 1. Decedent's Name (First, Middle, Last) NOVEMBER Day 11, 2006 2:10P.M **Physician** ROSENSTEEL RICHARD **JAMES** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Dunda1k 7611 Meadow Way | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0 Ct3,1936 . Sex 1 M 2 □ F 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Maryland 70 218-32-3921 Yrs. Director Usual Residence of Decedent the Maryland 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County show r 28a-f show 1 Tyes X No Director Dunda1k Md. Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or items 23a or 3 21222 USA 7611 Meadow Way Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 Ares 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ the Medical Exer-3 Widowed 4 Divorced 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry permit. Pages 1 and 2 should be filed within; Department of Health and Mental Hygiene important: If item 27 is marked other than "reny injury or other traumatic event, Ita Madagne. Elementary/Secondary (0-12) College (1-4or 5+) Welder General Motors 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marie McClaine Leo Rosensteel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7611 Meadow Way Baltimore, Md. 21222 Ruth Rosensteel (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Stanislaus 11-15-06 Baltimore, Maryland 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facilit Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee tuloT 1201 Dundalk Ave. Baltimore, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) molatale conver **Physician** 2 MUNTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine A pue burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): the attending physician Box 68760, Physician/Medical the t USB BS IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. P 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 90 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 XNo 1 Yes After this certificate 1 ☐ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: 4 Nursing Home 5 A Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident hours after death uneral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral D Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier well 019714 30. Name and address of person who completed EATERT AVE BALTIMAE MID 21224 MATE 11 MICHAIZL 31. Date filed (Month, Day, Year) #32. Registrar's Signature State 2006 Registrar 4

2. Date of Death 1. Decedent's Name (First, Middle, Last) ¹10, 2ŎO6 6:12 A M November Norman R. Schlee 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Manor Care Woodbridge Valley Baltimore Catonsville 8. Date of Birth (Month, Day, Year) FEB 21, 19 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Days Hours 1 M 2 □ F 216-16-8460 82 1924 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If I flem 27 is marked other than "nature!" any injury or other traumatic excessions. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Catonsville Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 402 Roanoke Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 XYes 2 No If Yes, Give Year or Dates: WW II 1 ☐ Yes 2 XNo Specify: 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Public Utility Company Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sch1ee Molly Andrews John 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3982 View Top Road Ellicott City, MD 21042 Gary A. Schlee, son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Mt. View Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 11/14/06 Marriottsville, MD 22. Name and Address of Facility MacNabb Funeral Home, P.A. 21. Signature of Funeral Service Licensee George MacNabb 301 Frederick Road Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEREBROVAS-ULAR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DIABETES 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1∐ Yes 2 🗖 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA 2 ER/Outpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □ Yes 2 □ No within 24 hours after deam.

To the Funeral Director: / 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0059107 11-10-2006 MiD 1241 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 210 BUSINESS MD 21136 CENTER REISTERSTEWN DRIVE UMA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 5, 2006 **Physician** 21:58 Grace Elizabeth Sexton /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Edgewood 2025 Starr Street 8. Date of Birth (Month, Day, Ye Jan. 26, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 1950 <sup>Year)</sup> **Funeral** Days Months Hours Maryland 1 ☐ M 2 ☐ F Yrs. 56 Director 215-56-5217 Usual Residence of Decedent 10d. fnside City Limits 10a. State 10c. City. Town or Location 10b. County show ref, or items 23a or 28a-f shov Examiner must be notified at Edgewood 1 TYes 2 No Harford Md. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21040 U.S.A. 2025 Starr Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married White Baltimore, Maryland 21215-0036 1 Tyes 2 No Specify Specify þ 3 ☐ Widowed 4 ☐ Divorced "neturef" in Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Colfege (1-4or 5+) Efementary/Secondary (0-12) own home homemaker permit. Pages 1 and 2 should be filed v Department of Heelth and Mental Hygien Important: If item 27 is marked other It any injury or other traumatic event, IIIA ODGE. 10 years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Grace E. Taylor William D. Sanders 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 2025 Starr Street, Edgewood, MD 21040 Kyle Sexton/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 11/8/2006 Bayview Crematory Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. aneo J B 610 W. MacPhail Read, Ecl Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Finaf disease or condition resulting in death) Atherosclerotic cardiovascular disease **Physician** /Medical Due to (or as a consequence of): Examiner diabetes S quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physicien: The law requires that the death certificate be executed physicien and s the burial-transit hypertension Due to (or as a consequence of): Records, P.O. Box 68760. high cholesterol Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) signed by the at d be detached to 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1X Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No Division of Vital after death.

Director: After this certific
in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 28c. fnjury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral Di completely filled in Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier name 30. Name and address c person who completed cause of death (Item 23a) (Type, Print) Averill Rd 32 Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 4 2006 and Registrar

		•	For State Registrar	State of Maryland /		ent of Health a	nd Men	tal Hygiene	ZUUb	35987
	Physicia	an	1. Decedent's Name (First, Middle, Last	)				Date of Death Month Da	APPK D	3. Time of Death
	/Medic Examin	al	Stella Simmons  4a. Facility Name (If not institution, give  Bel Art Hall)	street and number) and kehab	46. B	City, Town, or Location of		V -	County of Dear	n 1-4071 m
Ī	Funeral Director		5. Social Security Number 6. Se 377-18-4457	7. Age (In yrs. last to x y y y y y y y y y y y y y y y y y y	birthday) If U Yrs. Mor	inder 1 Year   If Under 2	Min.	Date of Birth Month, Day, Year) pr. 19,	9. Bird Co 1914 Mic	hplace (State or Foreign untry) chigan
	and and		Usual Residence of Decedent  10a, State 10b, County	10c. City, To	own or Location	1				10d. Inside City Limits
	Maryl -f aho	tor	Md. Harfo	rd	Fo	rest Hill				1 ☐ Yes 2 █KNo
	or 28s	lrec	10e. Street and Number		10	f. Zip Code		10g. Cit	izen of What Co	ountry?
	ath wi	rai	1602 Honeysuckle		10.145	21050	:-2 /C4		J.S.A.	ninga Indian
936	urs after de al', or itam examiner n	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 弦 No If Yes, Give Year or Dates:		Decedent of Hispanic Orig specify Cuban, Mexican, es 2  No Specify:	Puerto Rica	n, etc.)	Black, Whit	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28s-f ahow any injury or other traumatic avent. The Medical Examinar must be capilled at ODGs.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give kind o life. DO N	Usual Occupation of work done during most OT use retired)	of working	16b. K	ind of Business	Industry
2	Hygier Hygier thar th		12 years  17. Father's Name (First, Middle, Last)		inspec		's Name (Fir	rst, Middle, Maiden	aper con	ipany
and	id be fental b	To Be	Joseph Koscik				nerine		,	
Maryland	nd 2 shou ilth and M 27 is mer r treumsti	_	19a. Informant's Name/Relationship (T) William Bojarski		_	dress (Street and Number oneysuckle I				
Jre,	of Hea of Hea item		20a. Method of Disposition	ceme	e of Disposition	(Name of or other place)	Date	20c. Le	ocation - City or	Town, State
Baltimore,	ment ment tant: it		1 ☐ Burial 2 ☐ Cremation 3 反 4 ☐ Donation 5 ☐ Other (Specify,	) Mt. C	Olivet		1/14/			Michigan
Ball	permit Depart Import any in		21. Signature of Funeral Service Licens		61	ne and Address of Facility himunek Funé O W. MacPhai	1 Roa	d, Bel At		21014
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	tications'that caused the death. Done cause on each line.	Do not enter the	mode of dying, such as o	ardiac or re	spiratory arrest,		Approximate Interval Between Onset and Death
L	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	aDue to (or as a consequence	nal .	failure				mos-yrs.
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8760,	icate be executed physicien end s the burial-transit	Icai	Ĺ	d						
P.O. Box 6	The law requires that the death certificate be executed sie has been signed by the attending physicien end page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 Ecto	pic pregnancy or (specify)			23d. Date of de Month	livery Day Year
	juires that n signed by ild be deta	Ď	Part II. Other significant conditions co	intributing to death but not resulting	ng in the underly	ring cause given in Part I.		23e. Did tobacco		o the cause of death?
Records,	he law require s hes been sig ge 2 should b	Completed	DM.					24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
tal	en: T tificeta tor, pa	0	25. Was case referred to medical	-716		26. Place		1 Yes 28 No	1 Tes	2 🗆 No
of Vital	hysici nis cer i direc	To B	examiner? 1 ☐ Yes 2/X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/	/Outpatient 3		sing Home	5 Residence	6 □Other (Spe	cify)
ion o	Attanding Physician: If death. Sector: After this certification in the funeral director.		27. Manner of Death  1 Natural 5 Pending  2 Accident investigation	(Month, Day Year)	b. Time of Injury M	28c. Injury at Work?		Describe how inju	ry occurred	
Division	tal or Att	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	, farm, street, f	actory, office	28f.	Location (Street as City or Town, State		ural Route Number,
	To the Hospital or Attending Physician: The within 24 hours effer death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page	Medical		ysician: To the best of my knowled iner: On the basis of examination and manner stated.		ation, in my opinion, deatl		t the time, date an	d place, and due	e to the cause(s)
)	To the within 2 To the complet	Σ	29b. Signature and title of certifier	· > ,		D56545			ite signed (Moni	h, Day, Year)
	10		30. Name and address of person who of SHILPI KHOSG	+ 296 HAYS	Ba) (Type, Print)	102, 1521	LAI	R, MD	2101	4
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Stella Simmons

			For State Registrar	State	of Maryla	•	artment rtificate			ınd M	ental Hy	giene,	2006	5	359	88
	Physici	an	1. Decedent's Name (First, Middle								2. Date of De Month	Day	Yea		3. Time of E	
	/Medic	al	EDGAR  4a. Facility Name (If not institution		SOLY number)		4h City 1	Town, or Lo	ocation of		Novemb	<del> "</del>	County of De		( ) ! -	i ivi
	Examin	er	JOHNS HOPKENS	-		CAL CENT		_	TEM				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
i	Funeral		5. Social Security Number	6. Sex	7. Age (In y	rs. last birthday,			If Under 2	24 Hrs. Min.	8. Date of Bir (Month, Da	rth	9. E	Birthpla	ce (State or	Foreign
	Director		016-26-1573	1⊠M 2□F	73	Yrs.	Montrio	Days	Tiours		Oct. 1	, 193	33 Ma		chuse	tts
	tand		Usual Residence of Decedent  10a. State 10b. County		10c.	City, Town or L	ocation							100	I. Inside City	Limits
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	deeth with the Maryland me 23a or 28a-f ahow Ernast be notified at	Director	10e. Street and Number	<u> </u>			10f. Zip	Code				10g. Citiz	en of What	Country	<b>y</b> ?	
	ath wi		1120 Bush Road					21009				USA				
	er der Itame	Funeral	11. Marital Status	Armed	ecedent Ever in Forces?	U.S. 13.	Was Decede If Yes, speci	ent of Hisp ify Cuban,	oanic Orig Mexican,	gin? (Spe , Puerto I	cify Yes or No Rican, etc.)	o- 1·	4. Race - Ar Black, W			
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7	be filed withintel Hygiene. Id other than event, the M		17, Father's Name (First, Middle,	(ast)		Lie	ıtenan		8. Mother	r's Name	(First, Middle		GOV	ern	ment	
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o e	ges 1 an t of Heal ff Item 2 or other		20a. Method of Disposition 1 ☐ Burial / 2 ☑ Cremation	3 ☐ Removal fro	op State	p. Place of Disp cemetery, cre	matory or ot	her place)			ate		ation - City			
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ä	permit. Depertium port		21. Signature of Funeral Service	Consee /		M		Fune	eral	Home	e, P. Abingo	A.	Maxx1-	Бос	21000	
H			23a. Part 1 Enter the disease, o	r complications th	at caused the de								матута	ρ.	Approximate of terval Between	
	Physician		stfock, or heart failure. List Immediate Cause (Final disease or condition		roke										nset and De	eath
	/Medical		resulting in death)	Due	to (or as a cons	,								Ť.		
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2	spital or ours afte neral Dir filled in															
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	To tha within 2. To tha complet	Me	29b. Signature and title of certifie				29c	License r	number			29d. Date	signed (Mo	nth, Da	ay, Year)	
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11	1		30. Name and address of person	who completed o				, ,								. 1
ĮV	7		TARA PERTI	, M D	497 2 Registrar's Sig	onature A	TERM	AVE	NUC	-	BALTE	MORE	MP	2	122	<i>T</i>
ı	Sta Registr		NOV 1 4	2006	2 Registrar's Si	S. A										

			1 - For State Registrar	State o	f Maryla	nd / Depa	artment <i>rtificate</i>			nd Me	ental ł	Hygiene Reg. No	71111	5	35989
	Physic		1. Decedent's Name (First, Middle Esther Irene S								2. Date of Month	Da			3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution		nber)		4b. City, 1	Town, or L	ocation of		VOUE,	MBEK 40	. County of D		07:55 M
			CITIZENS	NURSIN		ome		PRE	DE	- · · ·	PEE		HARF	ce	i
	Funeral Director		5. Social Security Number 229-24-9502 Usual Residence of Decedent	6. Sex 1 ☐ M 2 🔭	7. Age (In yrs 93	s. last birthday) Yrs.	If Under Months	1 Year Days	Hours	Min.		Dey, Year)	'	Counti	ice (State or Foreigr y) n Carolina
	yland		10a. State 10b. County		10c. C	ity, Town or Lo	cation							10	d. Inside City Limits
	Ba-f	Director	Maryland Har	ford		Street				-					1 ☐ Yes 2 No
	with the	Dire	10e. Street and Number				10f. Zip	Code				10g. Cit	tizen of What	Counti	y?
	ma 23	Funeral	3805 Prospec	t Rd.	dent Ever in l	J.S. 13.	Was Decede	154	panic Origin	n? (Spec	ify Yes or	US No.	5A 14. Race - Ar	merica	n Indian
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ည	72 hours "naturel",	eted	15. Decedent (Specify only highes	's Education		16a. Dece	dent's Usual	Occupati k done du	ion ring most o	of workin	————— п	16b. K	ind of Busine		
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and	0 0 0	Be	17. Father's Name (First, Middle,	Last)				1	_			dle, Maiden			
Maryland	should and Men amarke umartic	2	Wade (unk) ( 19a. Informant's Name/Relations)	TOUSE		19b. Mailir	na Address	(Street an				B Hode	JE or Town, State	Zin (	Code)
	od 2 27 La		Oleman D. Smith	ı/ Son		1.									MD 21078
Baltimore,	O O	1 3	20a. Method of Disposition 12 Burial 2 □ Gremation			Place of Dispo cemetery, crer	sition (Name	e of	1	Da		-	ocation - City		
E	t. Pag ntment rtent:		4 □ Dometion ¶□ Other (Se	Secify)		el Air				1-14			Air, M	lary	land
ga	permit. Page Department of Important: If eny injury or once.	5	21. Signature of Funeral Services	100	EC/	1	18001111 1317 C	okes	bury 1	Rđ.,	Abiı	ngdon,	, Maryl	and	1 21009
			23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complications that ca only one cause on ea	used the dea ach line.	th. Do not ent	er the mode	of dying,	such as ca	rdiac or	respirator	y arrest,		1	Approximate nterval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	or as a consec	DOUG	WW.	7							
	Examiner			00000	or as a corrsec	quence or):									
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (c	or as a consec	quer ou ut):							,	-	
	xecute and Il-trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (	or as a consec	Tuence of):									
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	rificat ng phy as the			0.											
DOX	death certific te attending pl ed for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♥ No	4□Pregna	th 2 ☐ Feta int at time of c	aldeath 3⊑	Ectopic pred Other (spec						23d. Date of d Month	,	ay Year
7. O	res thet the de signed by the a be detached t	Phys	9 Unknown	9∐ Unkno											
Records,	law requires thet as been signed b 2 should be deta	þ	Part II. Other significant condition	ns contributing to de	ath but not res	sulting in the ur	iderlying cau	use given	in Part I.			d tobacco u □Yes 2〔			cause of death?
ř	The ate his page	Completed								_	24a. W au pe 1 🗆 Yes	topsy rformed?	24b. Were a prior to death?	,	y findings available letion of cause of
VIta	Physician: 7 this certificar ral director, p	Be	25. Was case referred to medical examiner?	Hospital:					6. Place of						
5		n: To	1 ☐ Yes 2 ☐ ¥6 27. Manner of Death	28a. Date of	Injury	ER/Outpatient 28b. Time of		c. Injury at Work?	4 Nursir	ng Home	5 ☐ Red. Describ	e how injur	Other (Sp	ecify)	
5	Attending r death. ector: After by the fune	atio	1 Natural 5 ☐ Pending 2 ☐ Accident Investig	THE RESERVE AND ADDRESS OF THE PARTY OF THE	, Day Year)	Injury	М		s 2□No				,		
5	i Sign	Certification:	3 Suicide 6 Could n 4 Homicide determin	ned 286. Place of	of Injury - At h g, etc. (Special	ome, farm, stre	eet, factory,	office		28	Location City or 1	(Street and Town, State,	d Number or F	Rural F	loute Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai	29a. Certifier (Check only one) Certifying Medical E	Physician: To the t xaminer: On the ba- and mann	pest of my knows sis of examina or stated.	owledge, death ation and/or inv	occurred at estigation, in	the time, n my opin	date and paid on, death o	olace, and	d due to the at the time	ne cause(s) e, date and	and manner a place, and du	as state	ed. e cause(s)
	To t COM	Σ	29b. Signature and title of certifier	1	1 %	)	29c. I	License n	umber			29d. Date	e signed (Mor	th, Da	y, Year)
j	1		· The	as la	and a	,	į	134	1286	20		_/	1/10/6	6	i y
4			THomas	no completed cause	100	319 S		on Av	re, Ha	vre	de G	race,	MD 21	078	
	Sta Registr	-	31. Date filed (Month, Day, Year)		gistrar's Signa	iture	E)								

SMITH, ESTHER

		-	For State	State of Maryland		partment of H ertificate of I		_	- (	006	35990
			Registrar  1. Decedent's Name (First, Middle, Las	(t), A	-	Crimoate or i	Jean	2. Date of De	Reg. No.		3. Time of Death
п	Physicia		Zdivaca	d blac	-14	24 )	alim	Month	'ember	9 Z	206 1030 AM
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		40. City, Town, or	Location of Death		4c. Cou	nty of Dea	th
			Brighton Gardens	Assisted Livir	ng	Tows					re County
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. I	ast birthdi Yrs	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ıy, Year)	Co	thplace (State or Foreign
	Director		270-10-2280 Usual Residence of Decedent	94				July 6	, 1912	Cle	veland,Ohio
	yland		10a. State 10b. County	10c. City	, Town o	Location					10d. Inside City Limits
	8 Mar	ctor	Maryland Baltimo	ore Co. To	wson						1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Co	ountry?
	e 23a	E .	6451 North Charle	s Street 12. Was Decedent Ever in U.	c l	21204 3. Was Decedent of H	iannaia Origina /6	noofy Van or Ne	United		Les erican Indian,
	item item	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces?	S.   1	If Yes, specify Cuba	in, Mexican, Puert	o Rican, etc.)	E	Black, Whit	e, etc.
980	urs at	ام	3∕XWidowed 4 □ Divorced	1 XYes 2 □ No If Yes, Give Year or Dates: W.W.	II	1 ☐ Yes 2 💢 No	Specify:		Spe	icity: Wh	ite
21215-0036	72 ho	Completed	15. Decedent's Ec (Specify only highest gra		(G	cedent's Usual Occup- ive kind of work done	during most of wor	king	16b. Kind o	f Business	/Industry
2	ithin ne.	apple 1	Elementary/Secondary (0-12)	College (1-4or 5+)	1sf	e. DO NOT use retired	1)	•	Gener	cal T	25.7
2	iled w Hygiei ther ti	Š	17. Father's Name (First, Middle, Last)	07	ALL	orney	18. Mother's Nan	ne (First, Middle			aw
ano	ould be filed within 72 hours after death with the Maryland Mental Hydiene. And other than "natural", or iteme 23a or 28a-f show atto event, the Medical Examinar must be notified at	o Be	Naclev Salim				Hannah			,	
Maryland	should ind Men marke umatic	ဥ	19a. Informant's Name/Relationship (	Гуре, Print)	19b. M	alling Address (Street			er, City or To	wn, State,	Zip Code)
Ž	17 P B B B B B B B B B B B B B B B B B B		Ms. Joan H. Salir	n (Daughter)	561	3 Boxhill	Lane, Ba	ltimore	, Mary	land :	21210
ore,	of He of He r othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		lace of Di emetery, o	sposition (Name of crematory or other place	ce)	Date	20c. Location	on - City or	Town, State
<u><u>Ĕ</u></u>	Pagement ent: It ury o		4 Donation 5 Other (Specify	N) E/	ans	Funeral Ch	apel Nov	.10,200	Fore	est H	ill, Marylan
Baltimore,	permit. Pages 1 an Depertment of Heel Importent: If Item 2 eny Injury or other once.		21. Signature of Funeral Service Licer	see /		22. Name and Address		ves Film	eral&Cı	remat	ion Ctr. P.A
	40 = 0		Jan J. J	eju	Do 201					and,	ion Ctr. P.A 21093
			23a. Part1. Enter the disease, or com shock, or heart failure. List only fmmediate Cause (Final	one cause of each line.	1. DO NOT	enter the mode of dyin	ig, such as cardiac	or respiratory a	irrest,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Jemo	200	ha					7 years
	Examiner		- 1	Due to (or as a consequ	иепсе от).						V
		ē	Sequentially list conditions, lary leading to immediate cause. Enter Underlying	b. Due to for as a consequ	uence of:					-	
	cuted nd ransil	Examiner	Cause (Disease or injury that initiated events	c							
, 00	e exe	i Ex	resulting in death) Last	Due to (or as a consequ	uence of):						
8760,	The law requires that the death certificate be executed sie hes been signed by the attending physicien and page 2 should be detached for use as the bural-transit	dicai		_ d		<del>-</del>					
9 X	that the death certific ed by the attending p detached for use as	0	IF FEMALE:	23c. If yes, outcome of pregna	ncy				23d	Date of de	livery
Вох	atten atten	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		3 Ectopic pregnancy 5 Other (specify)	1		250.	Month	Day Year
P.O.	t the c by the achec	hysi	9 Unknown	9□ Unknown							
	res tha igned I be det	Completed by Physician/M	Part II. Other significant conditions of	ontributing to death but not resu	ulting in th	e underlying cause giv	en in Part I.	23e. Did	tobacco use o	/	o the cause of death?
ğ	v require been sii should t	ted	Myelop	roliferation	je_	ousoro	la	10	Yes 2 A	5 3∏P	robably 4 DUnknown
ecc	e law r hes be je 2 sh	ple	0					24a. Was	psy	prior to	utopsy findings available completion of cause of
Division of Vital Records,		Con						1 ☐ Yes	2 No	death? 1 ☐ Yes	s 2□ No
Vita Vita	ilcian: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		tions all post Oth	26. Place of Dea		1.00	/	Assisted
of	는 는 트	. To	1 ☐ Yes 2 ☑ No 27. Mann of Death	28a. Date of Injury	ER/Outpa 28b. Tim	e of 28c. Injur	y at	ome 5 Res 28d Describe		Other (Specured	LIVING
lon	nding tth. :: Afte e fune	atlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Inju	ry Wor	nk? Yes 2∐No				,
<u> S </u>	Attendi or death. ector: A by the fu	HICE	3 Suicide 6 Could not b			street, factory, office			(Street and Nu	ımber or R	ural Route Number,
ā	rs after el Dire ed in b	Certification:	4   Hothload	Dulluling, etc. (Opecin)	· /			0.1, 0.70			
	To the Hospital or Attending I within 24 hours after death. To the Funarel Director: After completely filled in by the funer	edical	(Check only 2 Medical Exar	nysician: To the best of my kno niner: On the basis of examina							
	within 24 To the F complete	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens					th, Day, Year)
	7 × 5 8		255. Signature and trace of contribut	- Lance	a.			4			
•			30. Name and address of person who	completed cause of death /Item	23a) (Tv	pe. Print)	- ())	1	Vover	we	n 10, 2006
11	, , V		Co. Harris and addition of person will				•		1 - 0		
10	+1 Y		Dr. thomas Fi	nrcane 55	05	Honkins	Barrien	- (150	1e, 1	olhir	nreMD.21724
10	Sta Registr		31. Date filed (Month, Day, Year)	nvcane 55 32 Aggistrar's Signa		Hopkins Roads	Bayvien	- (150	1e, 19	oalkir	nce MD. 21729

**Physician** /Medical Examiner The law requires that the death certificate be executed

and

attending physician

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

or be

"natural", or items 23a edical Examiner must b

the Medical

if Health and Mental Hyg If Health and Mental Hyg Item 27 is marked other other traumatic event, the

permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other th

Pages 1 and 2 should nent of Health and Men

filed within 72 hours after death with the

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760,

the Hospital or Attending Physician:

To the Hospital within 24 hours at To the Funeral D

After

Director:

Director

Funeral

Be Completed by

2

ed by the a been signed by t should be detach

Examiner Physician/Medical 9 Completed Be Certification: To Medical

9 Unknown

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural

29a. Certifier

31. Date filed (Month, Day,

5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year) Injury

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

N. Charles St. Balto Md 21208

(Check only one) 29b. Signature and title Acertifie

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 BINC

> Year) 2006

Pagistrar's Signature

DHMH\_17 Rev 1/2001

State

Registrar

			1 - For State Registrar	State of Maryla		artment of ertificate o			giene Reg. No 2 0 0	6 35992
	Physici		Decedent's Name (First, Middle, La     M A M I T.	S /	11 TH	-		2. Date of Dea Month No VEM A	Day \	7ear 006 09 c 5 M
	/Medic Examin		4a. Facility Name (If not institution, gin		AL	4b. City, Town	o, or Location of De		4c. County of	
	Funeral Director			Sex 1 □ M 2 \ F   7. Age (In y	rs. last birthday Yrs.	) ff Under 1 Ye Months Day				9. Birthplace (State or Foreign Country) NORTH CAROLINA
	Aaryland abow	ō	10a. State 10b. County MD BALTIM		City, Town or L					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th the 7	Irect	10e. Street and Number			10f. Zip Cod	9		10g. Citizen of Wh	nat Country?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hyglene. Important: if Item 27 is marked other than "netural", or Items 23e or 28s-f ahow any Injury or other traumatic avant, the Madical Exemplar must be notified at once.	y Funeral Director	9904 CERVIDAE I  11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give	1 U.S. 13.			(Specify Yes or No- erto Rican, etc.)	USA  14. Race Black, Specify:	- American Indian, White, etc. BLACK
21215-0036	hin 72 hours s. an "natural', Madical Ex	Completed by	3 Widowed 4 Divorced  15. Decedent's E (Specify only highest gi	Year or Dates:	(Giv	edent's Usual Oc e kind of work do DO NOT use rei	cupation ne during most of w ired)	vorking	16b. Kind of Bus	iness/Industry
	d be filed wit ntal Hygiene ad other the	Be	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Las  THOMAS COX		NUI	RSES AID	18. Mother's N	lame (First, Middle,		
Maryland	12 should h and Me 7 ia mark traumatic	T <sub>0</sub>	19a. Informant's Name/Relationship PAULETTE DORSES				eet and Number or	Rural Route Numbe	er, City or Town, S	tate, Zip Code) MARYLAND
	ges 1 and of Heelt If Item 2: or other 1		20a. Method of Disposition	☐Removal from State	b. Place of Disp cemetery, cre	osition (Name of ematory or other)	olace) 11-	-16-2006		ity or Town, State
Baltimore,	permit. Pag Department Important: any injury o		4 □ Donation /5 □ Other (Spec 21. Signature of Vuporal Service Lice		. HIBNE		dress of FacilityPI	HILLIPS F	UNERAL HO	ILLS, MARYLAND DME, P.A. MARYLAND 21217
	Physician /Medical		23a. Part1. Enter the disease, or cor shock or heart failure. List one fmmediate Cause (Final disease or condition resulting in death)	npfications that caused the d y one cause on each line.  a	sequence of):	PILS		iac or respiratory ar	rrest,	Approximate Interval Between Onset and Death
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68760,	ficate be physicials the bu	edicai		d.						
P.O. Box	that the death certificate led by the ettending phys detached for use es the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etaf death 3	□Ectopic pregna □ Other (specify			23d. Date Mont	of delivery h Day Year
	sign d be	b	Part II. Other significant conditions	contributing to death but not	resulting in the	underlying cause	given in Part I.			oute to the cause of death?  B Probably 4 Unknown
Vital Records,	The ate h page	Completed						24a. Was autop perio 1 □ Yes	osy pri rmaed? de	ere autopsy findings available for to completion of cause of eath?
Vita	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:	2 ☐ ER/Outpatii	2□ DOA	Othor	Death (Check only o		(0
of	Attanding Physic death. actor: After this by the funeral di	-	1 Yes 20 No  27. Manner of Death  12 Natural 5 Pending investigati	28a. Of te of Injury (Month, Day Yea	28b. Time	of 28c. f	njury at Work? I □ Yes 2 □ No	9 Home 5 ☐ Resident 1	how infury occurred	
Division	호류등	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine			street, factory, offi	се	28f. Location (S City or Tox	Street and Number vn, State)	r or Rural Route Number,
	a Hoapitel 124 hours ( a Funeral letely filled	Medical C		Physician: To the best of my aminer: On the basis of examiner and manner stated.						
)	To th within To th comp	Me	29b. Signature and title of Pertifier	Nem &	en	29c. Lic	ense number			(Month, Day, Year) EN 8, 2026
	5		30. Name and address of person who		Item 23a) (Type JHC 1	ALT		71133		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) NOV 1 4 20	32. Registrar's S		ade				

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 3:-Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 11, 2006 Joseph John Sickoria, Sr. 7:00 AM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore

Under 1 Year | If Under 24 Hrs. | 8. Date of Birth

The Days | Hours | Min. March 1 94, Year) 25 Mercy Medical Center 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign M 2□ F Months 219-12-6372 81 West Virginia Vrs Director Usual Residence of Decedent death with the Maryland 10a State 10h County 10c. City, Town or Location or 28a-f ehow 10d. Inside City Limits other traumatic event, the Medical Exeminer must be notified at Director Md. 1 ☐ Yes 2 ☐ No n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 311 South Madeira Street 21231 USA or Itema 23a Funerai permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "naturel". or incorpose. 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Yes 2 No ρ 3 Widowed 4 Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker 12th Beth Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Michael Sickoria Julia Shober 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Sickoria, Jr. (son) 1402 Joppa Forest Dr. Unit N Joppa, Md. 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of JesusNov 15,2006 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facili Kaczorowski Funeral Home, Tolard 1201 Dundalk Ave. Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Kay disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner thew Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to or as a consequence of): and / use as the burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ director, page 2 should be Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1☐ Yes 2√2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2√ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) After ! 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident death. after death Director: / 1 ☐ Yes 2 ☐ No the 3 T Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 - Homicide within 24 hours a To the Funaral E (X) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. Unlike basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Chack only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) thankon, mb, FAGR D 51088 November 11, 2006 30. Name and addrage of person who completed cause of death (Item 23a) (Type, Print) Thaw Poon, 301 St. Paul Place #701 Baltimore, Maryland 21202 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 4 2006 Registrar

		Please T	ype or Print in I				-	_			
		1 - For Stata Registrar	State of Marylar		ırtment of l <i>tificate of</i>			lieg. No. 006	35994		
Physic /Medi		Decedent's Name (First, Middle, Last)     VLADIMI	R	SH	ULMAN		2. Date of Deal Month NoVEMBE	Day Yea	3. Time of Death 5', 45 Am		
Exami	ner		F BALTIMORE		BALTIM	or Location of Deat	TY	4c. County of D	N/A		
Funeral Director		5. Social Security Number 6. Security S	7. Age (In yrs.	**	If Under 1 Year Months Days			9. E 1930	Birthplace (State or Foreign Country) BELARUS		
Maryland -f ehow	tor	10a. State 10b. County  MD BALTIMO		ty, Town or Lo	cation GS MILLS				10d. Inside City Limits 1 ☐ Yes 2 ☐ No		
or 28e	Director	10e. Street and Number			10f. Zip Code		1	l0g. Citizen of What			
leath w	Funeral	104 PLEASANT RIDG	E DRIVE #313 12. Was Decedent Ever in U	I.S. 13. V	Vas Decedent of I	21117 Hispanic Origin? (S	Specify Yes or No-	14. Race - A	USA merican Indian,		
hours after death with the Maryland turel', or items 23a or 28e-f ehow al Examiner must be notified at	þ	1 Never Married 2 X Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		Yes, specify Cub		Specify Yes or No- to Rican, etc.)	Black, W			
in 72	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+) 5+	(Give		pation during most of wo ad)	rking	16b. Kind of Busine	,		
illed v I Hygia other t	Be Co	17. Father's Name (First, Middle, Last)	2+	ENGI	NEEK	18. Mother's Na	me (First, Middle, I	ENGINEERI Maiden Sumame)	NG		
should be ind Mental marked umatic ev	To B	ZOCI		SHULI		HASYA			NELSON		
and 2 sh ealth and n 27 is m		19a. Informant's Name/Relationship (Ty BROKHA OSTROVSKAY						r, City or Town, State - OWINGS	e, Zip Code)21117 MILLS,MD		
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)  20b. Place of Disposition (Name of cemetery, crematory or other place)									or Town, State		
permit. Departm Importa		ON & BROS	., INC.								
			Approximate Interval Between								
Pnysician /Medical		23a. Part1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):									
Examiner		Sequentially list conditions,	M Yo CARD	1 0	INFARC	TION			1 DAY		
xecuted and transit	xamine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	SEPSIS  Due to (or as a consequence)	uence of):					I PAY.		
icate be ex physician s the buria	dical E	L.	l								
The law requires that the death certificate be evite has been signed by the attending physician age 2 should be detached for use as the burian	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of continuous	aldeath 3 □	Ectopic pregnand Other (specify)	ey .		23d. Date of Month	delivery Day Year		
quires that n signed t	ē.	Part II. Other significant conditions con CHRONIC RENA			nderlying cause gr	ven in Part I.			to the cause of death?  Probably 4 Monknown		
The law requir ate has been si page 2 should	Completed						24a. Was a autops perforr	24b. Were prior death	autopsy findings available to completion of cause of		
ician: T certificat rector, pa	Be	25. Was case referred to medical examiner?	ospital:		0*	hor	ath (Check only on	16)			
G o A	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	t 3□ DOA 28c. Inju			ence 6 Other (S	pecify)		
To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special		M 1	Yes 2 □ No	28f. Location (St	treet and Number or	Rural Route Number,		
urs after rai Dira		4   Nonnelae					City or Town				
ne Hosp n 24 ho ne Fune bletely fi	edical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the treatment of the control of the con	ime, date and place opinion, death occ	e, and due to the caured at the time, d	ause(s) and manner late and place, and c	as stated. due to the cause(s)		
To the	ž	29b. Signature and title of certifier	1. MD			se number		29d. Date signed (Mo			
7		30. Name and address of person who co	mpleted cause of death (Iter	m 23a) (Type,	RES-			IOVEMBER.			
		MANISH ALGRA M 31. Date filed (Month, Day, Year)	D SINAL HO.	SPITAL ature	of BA	LTIMOR	E, BAC	TIMORE,	MD. 21215.		
Regist	tate trar	NOV 1 4 2006	32. Registrar's Signa	2004	(i)						

			1 - For Amend I	State of tems 23	Marylande, <b>24a</b> , 2	d / Deps 5,26	artment	t of H	ealth a <b>Dr</b> Seath	and N , <b>G86</b>	lental Hy 1,11/14	giene 1/06d	<b>J</b> 0 6	35995
	Dhysia		1. Decedent's Name (First, Middle, Las								2. Date of De	ath		3. Time of Death
-	Physic /Medi		Frank Amo Taylor								Month Octobe	Day r 29.	2006	1:37 AM M
1	Exami	ner	4a. Facility Name (If not institution, give	street and num	iber)		4b. City,	Town, or	Location of	of Death			ounty of Deat	
			3605 63rd Avenue 5. Social Security Number 6. Se		* * //-			ndoy				Pr	ince G	eorge's
	Funeral Director			X ZM 2□F	7. Age (In yrs. Ii 87	ast birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birt (Month, Da	h y, Yea <i>r)</i>	Co	hplace (State or Foreign untry)
			Usual Residence of Decedent		07						Apr 9,	1919	Nor	th Dakota
	how thow	_	10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Ba-f	Director	MD Prince (	eorge's	3	La	ndove	r						1 ☐ Yes 2 ☐ No
	with th	E C	10e. Street and Number				10f. Zip	Code				10g. Citize	n of What Co	untry?
	eath	erai	3605 63rd Avenue	12 Mas Dass	dont Francis II 6	10.1	** 5		2078				USA	
Maryland 21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or iteme 23s or 28s-1 show styling or other traumatic event, if a Medical Examinar must be notified at ODGs.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	Armed For			Vas Decede IYes, speci I□Yes 2		spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)	1	. Race - Ame Black, White pec <i>ify:</i> Wh	e, etc.
20	72 ho	Completed	15. Decedent's Edi	cation	35-4.	16a. Deced	lent's Usual	Occupa	tion			16b. Kind	of Business/I	Industry
21	ithin 7	npie	(Specify only highest grad Elementary/Secondary (0-12)	College (1-	4or 5+)	(Give . life. [	kind of worl OO NOT use	k done d e retired)	uring mosi	t of worki	ng			
2	led w lygier her th	Š	12	0		adve	rtisi						lishin	g
ano	ntal H	Be	17. Father's Name (First, Middle, Last) Frank Albert Tay.	0.16							(First, Middle,	Maiden Su	<i>im</i> ame)	
Ž	hould d Me mark matic	T <sub>o</sub>	t9a. Informant's Name/Relationship (T			105 14-77								
Z	ith ar 27 io 27 io r trau		Carol Taylor/spous								Route Numbe	r, City or Ti 2078		lip Code)
ē,	s 1 er f Hea item other		20a. Method of Disposition			ace of Dispos	sition (Name	e of			ate		tion - City or 1	Town, State
Baltimore,	iit. Page extraent o ortent: If injury or in.		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify)		late	metery, crem		·						
Ba	Deperiment of the popular of the pop		21. Signatur Funeral Struice Licens Kona d S	1111 0	Ce-	Ba	1timo	re.	MD 2	21201	655 W.		imore :	Street
			23a. Pail 1. Enter the disease or combi shock, or heart failure. List only o	ications that ca ne cause on ea	used the death. ch line.	Do not ente	er the mode	of dying	, such as	cardiac o	r respiratory arr	est,		Approximate Interval Between
5	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		mous ce		cinom	na of	1un	g				Onset and Death  1 year
	Examiner			Due to (o	r as a conseque	ence of):								
		ē	Sequentially list conditions,		as a conseque	encerof):								
	ficate be executed physicien end is the burial-transit	Examiner	il any, leading to ininhediate cause. Enter Underlying Cause (Disease or injury that initiated events											
o,	en er en er irial-tr	EX	resulting in death) Last	_	r as a conseque	ence of):								
8760,	ate be hysici the bu	dicai		l										
	entific ling p	Med	IF FEMALE:											
.O. Box	The law requires that the death certificate be executed tie hes been signed by the attending physicien end bage 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birt	ome of pregnand th 2 Fetal of that time of dea on	leath 3 □t	Ectopic preç Other (spec					23d	Date of delive Month	rery Day Year
 J	res that igned b be deta	by Pr	Part II. Other significant conditions cor	tributing to dea	th but not result	ing in the un	derlying cau	ise giver	in Part I.		23e. Did tol	Dacco use	contribute to t	the cause of death?
Records,	w require been sig should by	ed b	coronary artery	lisease							1 <del>-</del> ∇ Y €	s 2 N	o 3 Pro	bably 4 Unknown
ပ္ ()	law re	Completed									24a. Was a	n 2	4b. Were auto	opsy findings available
ř	The lay	E									autops	ned?	prior to co death?	ompletion of cause of
VITa	sicien: certifica rector, p	Be	25. Was case referred to medical examiner?					111	26. Place	of Death	Check only on	e/No	1 ☐ Yes	2 No
5	Physic this co	2	1 ☐ Yes 2 🙀 No	ospital: 1 🗆 Inp		R/Outpatient	3□ DOA	Other			e 5 <b>X</b> Reside		Other (Specia	fy)
ב ב	Attending Physicien: r death. sctor: After this certific by the funeral director.	ë	27. Manner of Death 1 ★Natural 5 ☐ Pending	28a. Date of (Month,	Injury 2 Day Year) 2	8b. Time of Injury	280	. Injury a Work?	ıt		Bd. Describe ho			
<u>s</u>	ttend death stor: , the f	cat	2 Accident investigation 3 Suicide 6 Could not be	00 01	(1)		M		s 2 N					
DIVISION	ii or Attendii after death. I Director: A d in by the fu	Certification:	4 Homicide determined	building	Injury · At hom , etc. (Specify)	e, farm, stree	et, factory, o	office		2	3f. Location (St. City or Town	reet and No , State)	ımber or Rura	al Route Number,
	spita hours nerai		29a. Certifier 1 Certifying Phys	ician: To the b	est of my knowl	edge, death	occurred at	the time	date and	place at	ad due to the ca	usa(s) and	I mannar as s	tatad
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in by	Medicai	one)	er: On the bas and manne	is of examinatio	n and/or inve	stigation, in	my opir	nion, death	occurre	d at the time, da	ate and pla	ce, and due to	o the cause(s)
	T V V	Σ	29b. Signature and title a Certified		01.1		ł	License r			1		gned (Month,	* * * * * * * * * * * * * * * * * * * *
		,	00/10 11 basin	90 1				00008	0/54			Novem	ber 3,	
	JO		30. Name and address of person who	inpleted cause		3a) (Туре, Р 1525		100 V	rwai	, 1	to Din	ali se	Comesi	ipelt my
	Stat		31. Date filed (Month, Day, Year)		strar's Signatur				,~~	1	2/	.00	Orcen	well' WP
	Registra		NOV 1 4 2	- 40	Pagady e s	to A	23262	9						

210 Business

**ÓRIGINAL** 

32. Registrar's Signature

Center Dr.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

			1 - For Stete Registrer	State of Maryl	and / Depa	artmen rtificate	t of He	ealth a Death	nd M		giene) (	006	35997
			1. Decedent's Name (First, Middle, Last	")						2. Date of De.	ath		3. Time of Death
- Spin	Physic /Medi		Anthony Geor	ge T	oskov	Sr				Month Novembe	Day	Year 2006	12.25P M
	Exami		4a. Facility Name (If not institution, give	street and number)				Location of		TIO V CIMDI		inty of Death	The second secon
			1983 Poplar Ridge	Road		Pas	sadeı	na			An	ne Aru	ınde1
	Funeral		5. Social Security Number 6. Se.	MM 2005	yrs. last birthday)	If Under Months	1 Year Days	If Under 24 Hours	4 Hrs. Min,	8. Date of Birt (Month, Da July 2	h v. Year)	9. Birth	place (State or Foreign
	Director		210-30-0097	6	8 Yrs.					July 2	7,1938	3	MD
	and		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation							10d. Inside City Limits
	Mary	ō	MD Anne Arur		Pasadena								1 ☐ Yes 21 No
	the 28a	rec	10e. Street and Number		1 40440110	101. Zip	Code		-		10g. Citizen	of What Cou	
	3a o	<u>=</u>	1983 Poplar Ridge	Road		2112					U.S.A		antry :
	d within 72 hours after death with the Maryland Jone. I then "naturel", or iteme 23a or 28a-f show the Medical Examinar must be multified at	by Funeral Director		12. Was Decedent Ever i		Was Deced	ent of His	panic Origi	n? (Spec	cify Yes or No-		Race - Ameri	ican Indian
9	after or its	E	1 ☐ Never Married 25 Married	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give		f Yes, spec	ify Cuban	, Mexican,	Puerto F	Rican, etc.)	E	Black, White,	, etc.
8	rei', c	l b	3 Widowed 4 Divorced	If <b>Yes,</b> Give Year or Dates:		1 ☐ Yes 2	No No	Specify:			Spe	city: W	hite
5-0	72 h natu	Completed	15. Decedent's Edu (Specify only highest grade	cation le completed)	16a. Dece	dent's Usua	Occupat	tion uring most o	of workin	4	16b. Kind o	f Business/In	ndustry
21	within ene.	훁	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT us	e retired)	_		9			
2	e filed withing Hygiene. I other ther		12		Shee	t Met		orker					Air Coolin
anc	D = D •	Be	17. Father's Name (First, Middle, Last)	-1			}		s Name	(First, Middle,	Maiden Sun	name)	
ž	2 should the and Ment is marked eumatic	5	Anthony George To					Elsie					
Maryland 21215-0036			19a. Informant's Name/Relationship (Ty	•						Route Numbe			o Code)
	1 and Heelth em 27 ther tr		Mr. Shawn Toskov  20a. Method of Disposition	•	L414 b. Place of Dispo	Tiema	n Dr	ive G	Len	Burnie			
و	ages nt of : if it		1  ☐ Burial 2 ☐ Cremation 3 ☐ P	lemoval from State	cemetery, crer	natory or oti	her place,		v. ]	.5,	20c. Locatio	on - City or To	own, State
Baltimore,	ritme ritani njury	1 7	4 □ Donation 5 □ Other (Specify)  21 Signature of Funeral Service License		len Have			•	2006		Glen E		
Ba	permit. Pages 1 and Department of Heelth Important: if item 27 eny injury or other to		21. Signature of Pureial Service Liberts	no		. Name and			DII	ngleton	Funer	al Hor	me, P.A.
		-	23a. Part 1. Enter the disease, or compli	cations that caused the d	eath Do not eat	Secon	id Av	renue	SW C	Glen Bu	rnie,	MD 210	
	43-		shock, or heart failure. List only or tmmediate Cause (Final	ie cause on each line.			94						Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)		11076	Scu	car	/ (	011	9 6 54	e		
	Examiner	1.9		Due to (or as a cons		V . 2	0	(0.45)	1 0				
		<u>ت</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):	416		410	Cev			_	
	uted ansit	듣	cause. Enter Underlying Cause (Disease or injury that initiated events	1	men	10	4 10	( -0 )					
Ć.	exec n an ial-tra	Examiner	resulting in death) Last	Due to (or as a cons			100						
68760,	cate be executed physicien and the burial-transit	dicai	L.	I									
	tifica ig ph as th	ed											
Вох	death certific e attending p id for use as	Physician/Me	230. Was decedent pregnant	3c. If yes, outcome of pre 1□Live birth 2□F		Ectopic pre					23d. [	Date of delive	ery
		SICIE	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of		Other (spe						Month	Day Year
P.O.	at the by th	h	9 🗆 Unknown										
o,	The law requires that the death sie hes been signed by the atter page 2 should be detached for u	by F	Part II. Other significant conditions con	tributing to death but not	resulting in the ur	derlying car	use given	in Part I.		23e. Did to	bacco use co	ontribute to th	ne cause of death?
Vital Record	w requir been si should	ted								1 🗆 Y	es 2 No	3 Prob	ably 4 Unknown
ပို	e law r hes be je 2 sh	Completed								24a. Was a		. Were auto	psy findings available
		NO.							_	autops perform	med? 2 No	death?	mpletion of cause of
ita	ysician: The is certificate he director, page	Be	25. Was case referred to medical examiner?			1 - 1 1 1	2	26. Place of	Death (	Check only on		1 1 1 1 1 1 1 1	2   140
	Attending Physician: r death. ector: After this certific by the funeral director.	To.	1 Yes 2 No	ospital: 1 Inpatient 2	☐ ER/Outpatient	3□ DOA	Other:	4 🗆 Nursi	ng Home	5 Heside	ence 6 🗆 C	ther (Specifi	v)
_	ding Ph h. After th funeral		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year,	28b. Time of Injury	28	c. Injury a Work?	it		d. escribe ho			
<u> </u>	tendi Jeath. tor: A the fu	catl	2 Accident investigation			М	1 □ Ye	s 2 No					
	i or Attenation after deati	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - Albuilding, etc. (Spe	t home, farm, stre	et, factory,	office		28	f. Location (St City or Town	reet and Nur 5, State)	nber or Rura	l Route Number.
	ospital of hours af hours af numeral Distriction in tilled in the control of the		0.015								,		
	To the Hospital or At within 24 hours after of To the Funeral Directionspletely filled in by	edical	29a. Certifier Certifying Phys (Check only 2 Medical Exemin	sicien: To the best of my k	nowledge, death ination and/or inv	occurred at estigation, in	t the time, n my opin	, date and p	olace, an	d due to the ca	ause(s) and r	manner as st	ated.
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and manner stated.			License n						
)	F 3 F 8			00 " "		250.	\ / \ / \ / \ / \ / \ / \ / \ / \ / \ /	277	4	1 2	9d. Date sign	iea (Montin, L	46
,	1		and while	XVII	\	1		001	1	1	II I	2 6	000
10	)		30. Name and address of person who cor	mpleted cause of death (II	tem 23a) (Type, F	rint) 7	ettre	27 6	. 5C	hm (	e.n	110	21111
	Sta	te	31. Date filed (Month, Pay, Year)	32. Registrar's Sig	nature	1		360	-( V )	17 7	- Cr V	1-(1)	1 -1170
	Registr		NUV 1 4 20	JUb	A A	23000	5						

			1_ For State	State of Mary				ntal Hygi	0000	05000
		_	Registrar		Cei	rtificate of De			N2006	35998
	Physici	an	1. Decedent's Name (First, Middle, L FRANK J	•	NTROP			Date of Death Month	Day Year	3. Time of Death
×	/Medic		4a. Facility Name (If not institution, gi	- WO	NIKUP	4b. City, Town, or Lo		VEMBER	4, 2006	7:30 P M
	Examir	lei	FOREST HILL HEALT		TATION		HILL		HARFORD	,
	Funeral		5. Social Security Number 6.	Sex 7. Age (In	yrs. last birthday)	If Under 1 Year If		. Date of Birth		place (State or Foreign untry)
	Director			¹□M 2□F 85	Yrs.	World Days	J.	Date of Birth (Month, Day, ) une 25,	1921 Mar	yland
	land land		Usual Residence of Decedent  10a. State 10b. County	100	. City, Town or Lo	cation				10d. Inside City Limits
	Mary Firsh	to	Md. Harfo	ord		Bel Air				1 ☐ Yes 2 🏝 No
	n the	Irec	10e. Street and Number	<u></u>		10f. Zîp Code		100	g. Citizen of What Cou	intry?
	23a c	ralD	1415 St. Francis	Road		2.	1015		U.S.A.	
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f show any righty or other treumatic event, the Medical Examination and Le colified at ODGs.	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 14 Yes 2 □ No If Yes, Give Year or Dates:	1	Was Decedent of Hispa f Yes, specify Cuban, f 1 ☐ Yes 2 ☐ No S	anic Origin? (Specit Mexican, Puerto Ric Specity:	y Yes or No- can, etc.)	14. Race - Amer Black, White Specify: V	
5	72 hc	etec	15. Decedent's § (Specify only highest g	ducation ade completed)	(Give	dent's Usual Occupatio	nn ing most of working		6b. Kind of Business/I	
121	within	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired)	•	(H	security	inty Gov't)
2	filed v Hygie ther t		11 years 17. Father's Name (First, Middle, Las	<i>t)</i>	secu	rity guard	8. Mother's Name (F	First, Middle, Ma		
an	ild be lental ked c	To Be	Frank Wontrop				Josephin			
Maryland 2121	shou and N smar		19a. Informant's Name/Relationship		19b. Mailir	ng Address (Street and Sharon Ac	Number or Rural F	Route Number, (	City or Town, State, Zi	p Code)
	and 2 ealth in 27 i		Thomas Wontrop/s						HILL, Ma.	. 21030
altimore,	Pages 1 ment of He tent: If iter jury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Spec	Removal from State		sition (Name of natory or other place) Crematory	11/7/2		Baltimore,	
Ball	Depart Depart Import any in		21. Signature of Funeral Service Lice	o Rinek	e S	Name and Address of Chimunek F	uneral Ho hail Road	1. Be1 A	Air, Md. 2	nc. 1014
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	nplications that caused the o one cause on each line.	death. Do not ente	er the mode of dying, s	such as cardiac or re	espiratory arres	t,	Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Ind of		curler				Cristian Dodgin
	Examiner			Due to (or as a con	sequence of):					
ŀ		Jer.	Sequentially list conditions, any loading to immediate cause. Enter Underlying	b. Diala to (or as a non	sequence of):					
	ransit	Examin	that initiated events	C.						
Ó,	e exer		resulting in death) Last	Due to (or as a con	sequence of):					
68760,	ficate be executed physician and the burial-transit	edical		d						
_	ding p		IF FEMALE:	23c. If yes, outcome of pre	annanov					
.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and right as should be detached for use as the burial-transitions.	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown	etel death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv	ery Day Year
J.	res that igned b be deta	by Ph	Part II. Other significant conditions	contributing to death but not	resulting in the ur	nderlying cause given in	n Part I.	23e. Did toba	cco use contribute to	he cause of death?
g	w require been sig should b							1 ☐ Yes	2 □ No 3 □ Pro	babiy 4 Unknown
Vital Records,	aw re	Completed						24a. Was an autopsy		opsy findings available
Ĭ		Com						performa	d?   death?	ompletion of cause of 2 \sum No
Ita	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			26	6. Place of Death (C			
0	hysi this c	To	1 ☐ Yes 2 No		2 ER/Outpatien				ce 6 ☐Other (Speci	fy)
u	ding f	tlon	27 Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time of Injury	28c. Injury at Work?  M 1 Tyes	280 2 🗆 No	I. Describe how	injury occurred	
Division	death death ctor: y the	flcat	2 Accident investigation 3 Suicide 6 Could not 1	De Dines of Injury	At home, farm, stre			. Location (Stree	et and Number or Run	al Route Number.
2	a after	Certification;	4 Homicide	building, etc. (Sp	ecify)	,,		City or Town, S		
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director.	edical (	29a. Certifier 1 Certifying P (Check only one) 2 Medicel Exe	hysicien: To the best of my miner: On the basis of exan and manner stated.	knowledge, death nination and/or inv	occurred at the time, overtigation, in my opinion	date and place, and on, death occurred	I due to the caus at the time, date	se(s) and manner as s a and place, and due t	stated. the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier			29c. License nu	ımber	29d	. Date signed (Month,	Day, Year)
,	, ,		Daw 5	2		032	251	no	ovember	C, 2006
	10+1		30. Name and address of person who			Print)	, , ,			7
	* 20	t à	DR. DAVID DUNN  31. Date filed (Month, Day, Year)	615 W. MACPH		- BEL AIR	. MD 2101	4		
	Sta Registr	_	NOV 1 4 2	32. Registrar's S	griature	Prince				
			NUV 1 & Z	UUU   The see	JA Red	STATE IT				

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			,	Certifica	te of Death	,	Reg. No.	6 35999
		1. Decedent's Name (First, Middle, Las.	)			2. Date of De Month		3. Time of Death
475	Physician Medical					11		606 1:44 Am
Ĵ	Examiner	4a Fecility Neme (If not institution, give		1		or Location of Deat	h 4c. County of	Death
22.		UNIVERSITY OF MI	ALYLAND MEDIC	al Center		TIMORE		
	Funeral	5. Social Security Number 6. Se	7. Age (In yrs.	lest birthday) If Uno	er i Year I i Under 24 i	Hrs. 8. Date of Bir Min. (Month, Da	th uy, Year)	Birthplace (State or Foreign Country)
	Director	215-16-1827	83	Yrs.		05	26 23	MD
	and s	Usual Residence of Decedent  10a. Stete 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits
	the Maryland 28a-f ahow							1 ☐ Yes 2 ☐ No
	with the Ma	MD NA 10e. Street end Number	Ba	ltimore 100.2	ip Code	1	10g. Citizen of Wha	at Country?
	death with ms 23a or c must be c		7					
	r flems 23a	629 Hillview Ro	12. Was Decedent Ever in U	,S. 13. Was Dec	21225  edent of Hispanic Origin? ecify Cuban, Mexican, Pi	? (Specify Yes or No	U . S	A     American Indian,
		1 Never Married 2 Married	Armed Forces? 1 ☑ Yes 2 ☐ No			uerto Rican, etc.)	Black,	White, etc.
070	urs a	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Detes:	1 ☐ Yes	No Specify:		Specify:	Black
21215-0020	led within 72 ho ygiana. Per than "nature nt, the Medical.	15. Decedent's Edu (Specify only highest great		16a. Decedent's Us	ual Occupation ork done during most of	working	16b. Kind of Busin	ness/Industry
21	within 7 ana. than "r	Elementery/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	use retired)	working.		
	od win	12th grade	na	Steel			·	eel Corp.
Maryland	2 should be filed with e end Mental Hygiana. Is marked other than raumatic event, the N To Be Comm	17. Fether's Neme (First, Middle, Last)			18. Mother's I	Name (First, Middle	, Maiden Sumame)	
<u>ya</u>	Ment Ment Ment Ment Ment Ment Ment Ment			1	Julia	a Sembly	<b>,</b>	
lar	d 2 should th end Mer 7 is marks traumatic	19a. Informant's Name/Relationship (T)			ss (Street and Number or		-	
	of Heelth Item 27 r other tr	Beatrice Weems-			lview Road			1225
0.0	or of	20a. Method of Disposition  1) Burial 2 ☐ Cremetion 3 ☐ F	Removal from State	Place of Disposition (Nemetery, crematory or	other place)	Date	20c. Location - Cit	y or lown, State
Baltimore,	permit. Pages Depertment of Important: If I any injury or ance.	4 □ Donetion 5 □ Other (Specify)				. 11/13/	06 Owing	gs Mills, Md
3a	Deper Impor	21. Signature of Funeral Service Licens	66		and Address of Fecility h F/H West	<del>-</del>		
	= € a	1 × XVVVVVV O	any /ut	4300	Wabash Av	ve, Balt	imore,	Md 21215
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	icalions that caused the death	h. Do not enter the mo	de of dying, such as care	diac or respiratory a	rrest,	Approximate Interval Between
	Physician			,		2.4		Onset and Death
b	/Medical Examiner	Inmediate Cause (Final disease or condition resulting in deeth)	e. Chrumic Due to (o	[Nwhya	ytic Le	WKowne	\	! 
		Y	Due to (o	or es a consequence of	): '			1
	Page 15		Mulmoni	in for	1 Parlians			1
	al-tre	Sequentially list conditions, if eny, leading to immediate	Due to (o	r as a consequence of	dlitus			1
68760,	that the death certificate be assecuted.  ed by the ettending physician end detached for use as the bunel-trensit  Physician/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Diale	r as a consequence of				
89	ificati	resulting in death) Last	Due to (0)	as a consequence of	•			1
×	nding use a		d					
. Bo	death d for	Part II. Other significent conditione co	ntributing to death but not resi	ulting in the underlying	cause given in Part I.	23b. Did	tobacco use contri	bute to the cause of death?
P.0	The law requires that the death costs has been signed by the ettend page 2 should be detached for us Completed by Physiciary					10	Yes 2□No 3	Probably 4 Unknown
	w requires that is been signed to should be det					-	· · · · · · · · · · · · · · · · · · ·	
brd	een sign hould be					24a. Was	an autopsy 2 med?	24b. Were autopsy tindings available prior to
Records,	has be ga 2 sh					_		completion of cause of death?
<u> </u>	The ata h					10	Yes 2 No	1 ☐ Yes 2 ☐ No
Vital	ysician: The lis certificata ha diractor, paga	25. Was case referred to medical examiner?				Death (Check only	one)	
of V	Physician: this certific iral diractor,	1 ☐ Yes 2 ☐ No	lospital: 1 ☐ Inpatient 2 ☑				dence 6 Other	
ū	ng P Wfter t unare	27. Manner of Death 1 ☑ Naturel 5 ☑ Pending	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe	how injury occurred	
Division	tal or Attending P irs aftar deeth.  al Director: After t led in by tha funara  Certification:	2 Accident investigation 3 Suicide 6 Could not be	One Blees of Initial At he	M	1 ☐ Yes 2 ☐ No	29f Location (	Street and Number	or Rural Route Number,
Σ	or At aftar Olrec in by	4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	y)	ry, onice	City or To	wn, State)	ir Hurai Houle Ivumber,
ш	pital burs a filled filled	29a. Certifier 1 Certifying Phys	sician: To the best of my know	wledge death cooling	at the time date and of	ace and due to the	cause(s) and mann	er as stated
	To the Hospital or Attending Phys Within 24 hours aftar death. To the Funeral Director: After this completaly filled in by tha funaral di Medical Certification: To	(Check only 2 Medical Exami	ner: On the basis of examinal					
	vithin of the	29b. Signature end title of certifier		2	9c. License number		29d. Date signed (#	
	->-0	1 /-//	non	-	P5274	pq	11-07	1-06
	241	30. Name and address of posson who co	impleted cause of death (Item	1 23a) (Type, Print)		- 1	R	7-06 MAM, MO
	2	2414M HIRLAM		Sown	Charles Co	ner 21	230	
ę	State	31. Dete filed (Month, Day, Year)	32 Registrar's Signa	ture frete				

WEERNS, JUHN

			1 - For State Registrar	State of Ma	ryland /		rtment of H		nd M	_	giene Reg. No.	006	36000
	Physici /Medic		1. Decedent's Name (First, Middle, La Joan F. Watt							2. Date of De Month 11	Day	2006	3. Time of Death 12:20A M
	Examir		4a. Facility Name (If not institution, given 1315 Chesaco		114		4b. City, Town, or Rose	Location of				ounty of Death Baltir	
	Funeral Director		212-14-8263	Sex 7. Age	(In yrs. last t	oirthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Bir Month, Da 9 / 02 /	1 920	9. Birth Co En	nplace (State or Foreign unity) gland
	show	ō	Usual Residence of Decedent  10a. State 10b. County  MD Balt	imore	10c. City, To		cation osedale						10d. Inside City Limits 1 ☐ Yes ※No
	r 28a-f	Irect	10e. Street and Number				10f. Zip Code				10g. Citizer	n of What Co	untry?
	eth wit	ralD	1315 Chesaco	<del></del>				1237				USA	· · · · · · · · · · · · · · · · · · ·
920	urs after de al', or Itema Examiner n	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☼ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 X N If Yes, Give Year or Dates:			Vas Decedent of His Yes, specify Cubar	spanic Origin, Mexican, Specify:	in? (Spe Puerto i	cify Yes or No Rican, etc.)		Race - Ame Black, White pecify: Wh	e, etc.
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelih and Mental Hygiene. Department of Heelih and Mental Hygiene. Important: If item 27 is marked other than "refural", or items 23s or 28s-( show empty follury or other traumatic event, the Medical Examinar must be notified at ances.	Completed	15. Decedent's E (Specify only highest grant only highest grant only highest grant only (0-12)	ducation ade completed) College (1-4or 5-		(Give I life. D	ent's Usual Occupa kind of work done di OO NOT use retired)	tion uring most	of workii	ng		of Business/I	Martins
d 2	illed v I Hygie other t	Be Co	12 17. Father's Name (First, Middle, Last			R.	iveter			(First, Middle,	Maiden Su	mame)	. Martins
ylan	ould be Mental wrked	ToB	Francis J.							h A.			
Mar	nd 2 sh Ith and 27 is m r traum		19a. Informant's Name/Relationship ( Barbara Gorsu				g Address <i>(Str</i> ee <i>t a</i> 32 Harri						
	of Hee		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State		of Dispos	sition (Name of place	) No	vem	ber	20c. Locat	tion - City or	Town, State
Baltimore,	iit. Pag artment ortant: injury o		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lies	(y)	Park		d Cem.			2006			le, MD
Ba	Depa Impo eny i		Vifto B	lfh.		And	vans Fur d Cremat	eral ion	Ser	apel vices	Park	ville	erford Rd.
	Physician		Ja. Part. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused to one cause on each line a	-+-	o not ente	or the mode of dying	, such as c	ardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence	e of):	otar 1	roly	me	uresto	the		8 YEARS
	D ##	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	e of):		1					0 / 11,00
,09,	ate be executed obysicien and the burial-transit	dical Examiner	Cause (Disease of Injury that initiated events resulting in death) Last	cDue to (or as a	consequence	e of):			-				
68760	ng phys	Medic	IF FEMALE:	d									
P.O. Box	es that the death certifica igned by the ettending ph be detached for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 Hoo 9 Unknown	23c. If yes, outcome o 1☐Live birth 2 4☐Pregnant at ti 9☐Unknown	Fetal deal		Ectopic pregnancy Other (specify)				23d	d. Date of deli Month	very Day Year
	The law requires that the sie has been signed by the page 2 should be detach	þ	Part II, Dther significant conditions of	contributing to death but	not resulting	in the un	derlying cause give	n in Part I.			obacco use		the cause of death?
i Reco	The law resete has been page 2 sho	Completed								24a. Was autor perfo		prior to death?	topsy findings available completion of cause of
Vita	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:				26. Place o		(Check only o		30.4	
ام ر	ng Physter this	on: To	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day	t 2 ☐ ER/C 28b. Year)	Time of Injury	3□ DOA 28c. Injury Work			8d. Describe		Other (Spec	city)
Division of Vital Records,	or Attending ifter death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	9 200 Place of lains	y - At home,		M 1 7	es 2 □N		8f. Location (S City or Tov		lumber or Ru	ral Route Number,
u	To the Hospital or Attending Physician: The law within 24 hours efter death. To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical Ce	29a. Certifier (Check only one) Certifying Ph	sysician: To the best of niner: On the basis of e and manner state	examination a	ge, death ind/or inv	occurred at the time estigation, in my opi	e, date and nion, death	place, a	nd due to the	cause(s) and date and pla	d manner as ace, and due	stated. to the cause(s)
	To th withir To th comp		29b. Signature and title of certifier	nl	10-	`	29c. License	number	111	2	29d. Date si	igned (Month	n, Day, Year)
	,<		30. Name and address of person who	sarella,	ath (Item 222)	V.	DOC	366	54	)	rove	ember	13, 2006
5	)		Dhilip Pan  30. Name and address of person who  PHILIP PANZA	EECGA, M	D 90	CO 1	FRANKLI	N 50	BUA	eE DR	IVE,	BAL	TIMORE
	Sta Registr	te ar	31. Date filed (Month, Day, Year) NOV 1 4 2006	32. Registrar	's Signature	med	وع						